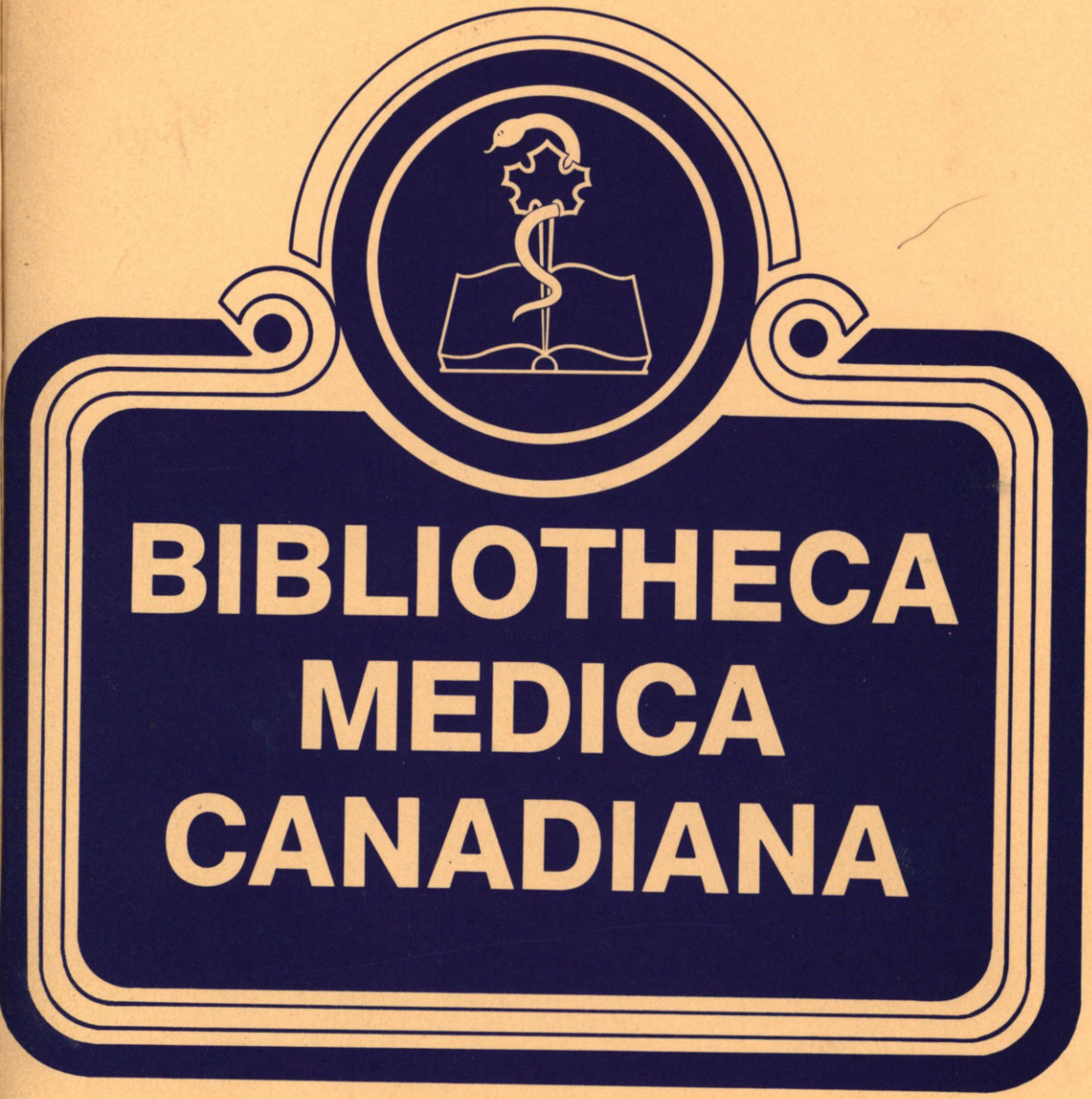

BIBLIOTHECA MEDICA CANADIANA

VOLUME 8 NUMBER 3 1987 ISSN 0707 - 3674

INFORMATION FOR CONTRIBUTORS / AVERTISSEMENT AUX AUTEURS

The **Bibliotheca Medica Canadiana** is a vehicle providing for increased communication among all health libraries and health sciences librarians in Canada. We have a special commitment to reach and assist the worker in the smaller, isolated health library. Contributors should consult recent issues for examples of the type of material and general style sought by the editors. Queries to the editors are welcome. Submissions in English or French are welcome, preferably in both languages.

La **Bibliotheca Medica Canadiana** a pour objet de permettre une meilleure communication entre toutes les bibliothèques médicales et entre tous les bibliothécaires travaillant dans le secteur des sciences de la santé. Nous nous engageons tout particulièrement à atteindre et à aider ceux et celles qui travaillant dans les bibliothèques de petite taille et les bibliothèques relativement isolées. Si vous désirez nous soumttre un manuscrit, vous êtes prié de consulter quelques livraisons récentes de la revue pour vous familiariser avec le contenu et le style général recherchés par la rédaction. La rédaction recevra avec plaisir vos questions et observations. Les articles en anglais ou en français sont bienvenus, de préférence dans les deux langues.

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PUBLISHING SCHEDULE 1986 - 1987 CALENDRIER DE PUBLICATION:

Deadlines for submission of articles to the next two issues are as follows:

volume 8, number 4	13 March 1987
volume 9, number 1	12 June 1987

La date limite de soumission des articles pour chacun des deux prochains numéros est la suivante:

volume 8, numéro 4	13 mars 1987
volume 9, numéro 1	12 juin 1987

Indexed In / Indexé Par :

Library and Information Science Abstracts (LISA)
Cumulative Index to Nursing and Allied Health Literature (CINAHL)

INFORMATION FOR CONTRIBUTORS / AVERTISSEMENT AUX AUTEURS

MANUSCRIPTS

The editors of **Bibliotheca Medica Canadiana** welcome any manuscripts or other information pertaining to the broad area of health sciences librarianship, particularly as it relates to Canada and to specific theme issues as they occur.

Contributions should be submitted **in duplicate** and the author should retain one copy. Contributions should be **typed double-spaced** and **should not exceed six pages or 2100 words**. Pages should be numbered consecutively in arabic numerals in the top right-hand corner.

All contributions should be accompanied by a covering letter which should include the author's (typed) name, title and affiliations, as well as any other background information that the contributor feels might be useful to the editorial process.

Articles may be submitted in French or in English but will not be translated by the editors or their associates.

Style of writing should conform to acceptable English usage and syntax; slang, jargon, obscure acronyms and/or abbreviations should be avoided. Spelling shall conform to that of the **Oxford English Dictionary**; exceptions shall be at the discretion of the editors.

Contributors who wish to submit their work in machine-readable format should contact the editors in advance to ensure that compatible equipment is available in the editorial offices.

REFERENCES

Contributors are responsible for the accuracy of their references.

Personal communications are not acceptable as references.

References to unpublished works shall be given only if obtainable from an address submitted by the contributor.

All references should be given in the Vancouver style; see **Canadian Medical Association Journal** 1985; 132: 401-5.

ILLUSTRATIONS

Any illustrations or tables submitted should be black and white copy camera-ready for print.

Illustrations and tables should be clearly identified in arabic numerals and should be well-referenced in the text.

Illustrations and tables should include appropriate titles.

INFORMATION FOR CONTRIBUTORS / AVERTISSEMENT AUX AUTEURS

MANUSCRITS

Les rédacteurs de la **Bibliotheca Medica Canadiana** sont à la recherche de manuscrits ou d'autres renseignments portant sur le vaste domaine de la bibliothéconomie dans le contexte des sciences de la santé. Nous recherchons tout particulièrement des articles relatifs à la situation au Canada et à des thèmes d'actualité.

Les articles devraient être remis **en deux exemplaires** et l'auteur devrait en garder une copie. Les articles devraient être **dactylographiés en double espace** et ne devraient **pas dépasser six pages ou 2100 mots**. Prière de numéroter les pages consécutivement en chiffres arabes en haut de la page à droite.

Tout article devrait s'accompagner d'une lettre de couverture fournissant les informations suivantes: nom de l'auteur (dactylographié), son titre et lieu de travail, ainsi que tout autre détail que l'auteur jugerait utile à la rédaction.

Les articles peuvent être remis en français ou en anglais, mais ils ne seront pas traduits par la rédaction ou par les associés de la rédaction.

Le style d'expression écrite se conformera à l'usage et à syntaxe acceptables du français; il est préférable d'eviter l'argot, les sigles et autres abréviations obscures. L'ortographe se conformera à celle du **Robert**; les exceptions à cette règle seront à la discrétion de la rédaction.

Les auteurs qui désirent remettre leurs manuscrits sous forme électronique devraient communiquer à l'avance avec la rédaction afin de s'assurer que l'équipement compatible est disponible aux bureaux de la rédaction.

REFERENCES

Les auteurs sont responsables de l'exactitude de leurs références.

Les communications de nature personnelle ne sont pas acceptables comme références.

Il ne faut citer une référence à un ouvrage inédit que si ce dernier est disponible à une adresse indiquée par l'auteur.

Toute référence devrait être citée selon le style dit de Vancouver; voir le **Journal de l'Association médicale canadienne** 1985; 132: 401-5.

ILLUSTRATIONS

Les illustrations et les tableaux doivent être en noir et blanc, et prêts à l'impression.

Les illustrations et les tableaux doivent être clairement identifiés en chiffres arabes et avoir des renvois clairs dans le corps du texte.

Les illustrations et tableaux doivent comporter des titres pertinents.

Bibliotheca Medica Canadiana News and Notes

The editors of **Bibliotheca Medica Canadiana** welcome news items from members of the Canadian Health Libraries Association, or any news that may be of interest to members. You are welcome to copy this form in any way for submission; news items too lengthy to fit on this form may be sent to the address shown below.

The copy deadline for volume 8, number 4 is : 13 March 1987

APPOINTMENTS ?
HONOURS ?
AWARDS ?
Who _____
What _____
When _____
Where _____

PROMOTIONS ?
MOVES ?
RESIGNATIONS ?
Who _____
From what _____
To what _____
When _____

SEMINARS ?
WORKSHOPS ?
What _____
When _____
Where _____

PUBLICATIONS ?
BOOK REVIEWS ?
What _____
Where _____
Bibliographic citation _____
_____

ACQUISITIONS ?
GIFTS ?
GRANTS ?
What _____
Why _____
Amount _____
Donor _____

TRIPS ?
LECTURES ?
VISITORS ?
Who _____
Where _____
When _____
Why _____

PLEASE FEEL FREE TO ADD MORE DETAILS. WHEN YOU RUN OUT OF SPACE, JUST ADD ANOTHER SHEET.

From _____
Address _____
Telephone _____

Send to: Tom Flemming, Editor
Bibliotheca Medica Canadiana
McMaster University Health Sciences Library
1200 Main Street West
Hamilton, Ontario L8N 3Z5

BIBLIOTHECA MEDICA CANADIANA

volume 8, number 3 1987

The Bibliotheca Medica Canadiana is published 4 times per year by the Canadian Health Libraries Association. Opinions expressed herein are those of contributors and the editor and not the CHLA.

Bibliotheca Medica Canadiana est publié 4 fois par année par l'Association des Bibliothèques de la Santé du Canada. Les articles paraissant dans BMC expriment l'opinion de leurs auteurs ou de la rédaction et non pas celle de l'Association.

CP / Box 983
Station B
Ottawa, Ontario
K1A 5R1

FROM THE EDITORS

It is not an easy task to edit a journal in two languages if you are proficient in only one of them. The current editors are not, of course, the first to face this difficulty, but consider the dimensions of the problem: how does one recognize misspellings, awkward syntax and turgid phraseology if one has little or no facility with the language? Imagine the difficulties involved in offering one's readers assurances of clarity and straightforward presentation of subjects in a language you don't speak, and read only occasionally. There are, naturally enough, solutions which can be bought. Translators abound in this country, and if you can pay the price, you can be assured of correct rendering of expression from one language to another, but that solution has not ever been within our means. Considerations of this nature led the editors, some time ago, to ask the Board to consider a change in policy which would permit publication of **Bibliotheca Medica Canadiana** in English only.

When raised at the November Board meetings in Hamilton (about which this issue has much more to report elsewhere), the question was settled in relatively short order. There will be no change in the policy of publishing material in both of Canada's official languages in **Bibliotheca Medica Canadiana**. As our association is a national one, we must maintain a willingness to address the membership in our official publication in either of our nationally recognized mother tongues. If the quality of expression in one of them, it was felt, is not entirely under the control of the editors, at least the opportunity for the membership to address their colleagues in the language of their choice has not been precluded by editorial policy. Maintenance of our two-language publishing policy was acknowledged by the Board to be more important than enabling the Editors to feel confident that the material they are publishing is well-expressed.

That is a decision which we accept gladly because of the clarity of its placement of values. We will continue to strive to deal with publication in two languages. We ask that readers who perceive our inadequacies in French be indulgent. Our *Information for Contributors/Avertissement aux Auteurs* section has been newly translated following the Board's decision and appears, for the first time fully in both languages, in this issue. We welcome papers in both languages, although we will not translate any, and will do our best to see that the quality of expression in each is as good as it is within our power to make it.

* * * * * *

Much of this issue is devoted to reporting on the November meeting of the CHLA/ABSC Board to which we alluded above. The President's report, the item on funding assistance for chapters, the report on strategic planning and the news item on the establishment of the task force on hospital library standards all arise from that meeting.

Several new features appear, also, in this issue: the continuing education page and the newsgathering form. We want to encourage readership participation in the production of **Bibliotheca Medica Canadiana** and hope that the introduction of these

features will assist us in achieving this goal. It is intended that the continuing education page will have a new author each time; it will provide an opportunity for people to share their expertise with each other without having to go to the length of writing a formal paper to do so. The newsgathering form is an invitation to our readers to let us know what is going on in every corner of the country where members of the association live and work. Our correspondents provide valuable coverage from several regions of the country already, but even within these areas it is not possible for them to know everything that might be of interest to readers of this journal and we hope, by opening up the responsibility of reporting news to the whole of our readership, to achieve better coverage of the health libraries scene in Canada.

The paper by Dr. Margaret Somerville beginning on page 126 of this issue was initially presented at our June 1986 conference in Montréal. Dr. Somerville was the keynote speaker at that conference and she gave a presentation which sparked a great deal of interest and much discussion. We asked that she prepare her address for publication and are very pleased to be able to include it in this issue.

Several of the other papers appearing in this issue deal with the theme announced on page 100 of v.8(2): *Technical Services in Health Sciences Libraries*. The announcement of themes has not provoked any flood of contributions from readers and will therefore be discontinued. It appears to have been as inhibiting as it has been helpful. Various issues will continue to be theme based, but on the theory that announcement of a theme in advance may have precluded someone from sending us a paper on another issue since which would be inappropriate to the announced theme, we will simply ask that potential authors send us anything and everything they think we might publish. Long or short, formal or informal, papers which will not do as full-fledged "original papers" may well be useful in the *News and Notes* section. Please note the deadline for the next issue and resolve, as you read this, to sit down before that time and write something for the next issue.

Once again, the editors offer their sincere thanks for proofreading and red-pencilling (in two languages!) to Liz Bayley. Her contribution of time and moral support is very much appreciated by the editors; her dedication to *the right word / le mot juste* is something from which all our readers benefit also.

Tom Flemming
Editor

Lynn Dunikowski
Assistant Editor

A WORD FROM THE PRESIDENT

Dorothy Fitzgerald

Director, Health Sciences Library
McMaster University
Hamilton, Ontario

The Board of Directors of CHLA/ABSC met at the McMaster University Health Sciences Centre in Hamilton from 28 to 30 November 1986. Most of the Board members arrived a day early in order to tour the Health Sciences Library and meet with Hamilton colleagues.

The three-day Board meeting was longer than usual as it had been decided to combine the usual Fall and Winter meetings as a cost-saving measure for the association. Conference calls will be used, when required, over the winter months to deal with association business.

Thanks to the efforts of our Board members a great deal of action was taken at this meeting, and various references will be made to these actions in this issue of **Bibliotheca Medica Canadiana**.

The strategic planning process of the association is now well underway. This Board meeting was the forum for discussing the three major position papers. Bill Maes, our Treasurer, and I presented a position paper and plan of action on financial/business concerns; Ann Barrett, our Education Coordinator, presented an extremely thorough proposal regarding continuing education; and Hanna Waluzyniec, our Membership Chair, prepared a very useful discussion paper on public relations. These major topics were selected as the primary areas on which to focus as a result of Board discussions and very helpful feedback and suggestions from the chapters. A brief summary of the strategic planning process to date appears elsewhere in this issue and more detailed reports will be sent to the chapters early in 1987.

Babs Flower, the Project Officer for the Survey of Medical School and Teaching Hospital Libraries in Canada, attended the Board meeting on Saturday afternoon. This was the first opportunity for the Board to meet with Babs and the discussion period proved useful both for the Board and for Babs. It was agreed that it would be very important to have Babs present her preliminary findings at the CHLA /ABSC Conference in Vancouver this coming May.

Nancy Forbes, the 1987 Vancouver Conference Chair, presented a detailed report on the upcoming conference. The preliminary program accompanies this issue of **Bibliotheca Medica Canadiana** and lets us know that a trip to Vancouver in May will be very worthwhile.

The terms of reference for the $500.00 Grant to Chapters were approved and are reported elsewhere in this issue. In response to a motion at the last Annual General Meeting the Board also took a decision to introduce a reduced membership fee for retired members.

A decision was taken to establish a Task Force on Hospital Library Standards and Jan Greenwood, our President-Elect, will report on this activity elsewhere in this issue.

A number of other matters were discussed and resolved. Reports of many of these will be covered in this issue. I hope you will agree that the Board is moving forward on a number of important association fronts. I would like to thank all members of the Board for their valuable contributions.

* * * * * * * * * * * * * * *

QUELQUES MOTS DE LA PRESIDENTE

Dorothy Fitzgerald

Directrice, Bibliothèque des sciences de la santé
McMaster University
Hamilton (Ontario)

Le conseil d'administration d'ABSC/CHLA s'est réuni à Hamilton du 28 au 30 novembre 1986, au Centre des sciences de la santé de McMaster University. La plupart des membres du conseil sont arrivés un jour à l'avance pour visiter la Bibliothèque des sciences de la santé et pour rencontrer leurs collègues d'Hamilton.

La réunion a duré plus longtemps que d'habitude (trois jours) parce qu'il avait été décidé, pour des raisons d'économie, de combiner les réunions d'automne et d'hiver. Nous aurons donc recours aux conférences téléphoniques pendant les mois d'hiver pour traiter, le cas échéant, des affaires de notre association.

Grâce aux efforts de notre conseil d'administration, la réunion a été très active comme le rapportent ces pages.

Le processus de planification stratégique de l'association est bien lancé. Cette réunion a permis de discuter de trois mémoires importants. Bill Maes, notre trésorier, et moi-même avons présenté un mémoire et un plan d'action relatifs aux affaires financières et à la gestion; Ann Barrett, notre coordonnatrice à l'éducation, a soumis une proposition trés fouillée sur l'éducation permanente; et Hanna Waluzyniec, notre responsable des adhésions, a rédigé un document de travail très utile sur les relations publiques. Ces grands thèmes ont été retenus comme les premiers sujets à étudier à la suite des débats au sein du conseil et des réactions et suggestions très utiles que nous ont communiquées les sections régionales. Un bref

résumé de l'état actuel du processus de planification stratégique paraît dans ce numéro et des rapports plus détaillés seront transmis aux sections dans les premiers mois de 1987.

Babs Flower, responsable du projet d'enquête sur les bibliothèques des facultés de médecine et des hôpitaux affiliés aux facultés de médecine au Canada, a assisté samedi après-midi à la réunion du conseil. C'était la première rencontre entre le conseil et Babs, et la discussion s'est avérée très enrichissante tant pour le conseil que pour Babs. Il a été convenu qu'il serait très important que Babs présente les résultats préliminaires de son travail à la Conférence de l'ABSC/CHLA au mois de mai prochain, à Vancouver.

Nancy Forbes, responsable de la planification de la conférence de 1987 à Vancouver, a soumis un rapport détaillé sur les travaux préparatoires. Le programme provisoire, qui est inséré dans le présent numéro de la **Bibliotheca Medica Canadiana**, laisse à penser que cet évènement méritera certainement le déplacement.

Les conditions d'obtention de la subvention de 500 $ aux sections régionales ont été approuvées; on en rend compte dans le present numéro. A la suite d'une proposition à la dernière assemblée générale annuelle, le conseil a également décidé d'introduire une cotisation réduite pour les membres à la retraite.

Il a été décidé de créer un Groupe de travail sur la normalisation des bibliothèques hospitalières, et Jan Greenwood, notre future présidente, rendra également compte plus loin de cette activité.

D'autre questions ont été discutées et réglées. Plusieurs sont traitées dans ces pages. A n'en pas douter, le conseil a bien fait avancer les choses dans plusieurs domaines très importants pour l'association, et je profite de cette occasion pour remercier tous les membres du conseil de leur précieux concours.

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FUNDING ASSISTANCE FOR CHAPTERS

The following are the conditions for the awarding of the *CHLA/ABSC 10th Anniversary Commemorative Award*:

CHLA / ABSC 10th ANNIVERSARY COMMEMORATIVE AWARD
****

Amount:

$500.00, awarded annually

Name of the Award:

The Award shall henceforth be known and referred to as *The CHLA/ABSC 10th Anniversary Commemorative Award.*

Establishment of the Award:

The CHLA/ABSC 10th Anniversary Commemorative Award was established by the incumbent Board at the 10th Annual General Meeting, 12 June 1986, to commemorate 10 years of professional association.

Intended Recipients:

The Award recognizes that one of the most tangible means whereby the mission of CHLA/ABSC is accomplished is through the activities of its Chapters. The Award, therefore, is available to Chapters in order to further the mission of CHLA/ABSC.

Application for an Award:

1. All Chapters in good standing are eligible to apply.

2. The President of the Chapter must submit, no later than a month before the Annual General Meeting, a detailed written summary of the special activity on which judgement is to be based. The submission must be co-signed by any other member of the Chapter executive. This submission is distinct from any annual report submitted to the Board.

3. The activity which forms the basis upon which a Chapter applies for an Award may take place in a given year or be represented by the efforts of several years.

4. All applications must be submitted to the current President of CHLA/ABSC.

Rules Governing the Award:

1. The recipient will be declared by simple majority vote of the Board. If a Chapter which is under consideration for an award has more than one member on the Board, only one member shall be eligible to cast a vote.

2. The Board's decision will be final.

3. The Board may decide not to give the Award in a given year if submissions are not considered appropriate.

4. The Board's decision will be announced at the Annual General Meeting and be reported in **Bibliotheca Medica Canadiana**.

Criteria for Judging on Merit:

1. Size of Chapter vs. size of accomplishment.

2. Extent to which submission shows furtherance of CHLA/ABSC's mission.

3. Degree to which the activity will have lasting effects at the Chapter or national level.

4. Extent of Chapter membership involvement in the activity.

5. Extent to which the activity shows initiative and innovation in the promotion of CHLA/ABSC's mission.

****

The Board would also like to remind all members of Chapter executives of the availability of funds under Article V, Sections 5 and 6 respectively, of the **Canadian Health Libraries Association/Association des Bibliothèques de la Santé By-Laws**. These by-laws state:

> Chapters may apply to the Board of the Association for development grants to support or assist proposed Chapter activities of merit. The Board may make grants to Chapters at its discretion.
>
> Chapters may request that the Association provide programme loans to facilitate the organization of workshops, publications or other continuing education activities. The Association will consider each application on its merit.

The Board wishes to encourage all Chapters to take advantage of the opportunities provided through these by-laws and the newly established *CHLA/ABSC 10th Anniversary Commemorative Award*. Application forms for funding under Article V of the By-laws should be requested from the President.

THE STRATEGIC PLANNING PROCESS OF CHLA/ABSC

Dorothy Fitzgerald

Director, Health Sciences Library
McMaster University
Hamilton, Ontario

The strategic planning process for CHLA/ABSC was initiated by Diana Kent during her 1985-86 tenure as President. In October 1985, Diana wrote to all Chapter Presidents requesting input regarding the broad issue of long range planning for the association. During the fall of 1985 and the spring of 1986, chapters submitted extremely helpful reports on the strengths and weaknesses of the association and recommendations regarding our future directions. At the February 1986 Board meeting in Vancouver, there was formal approval to proceed with the strategic planning process and a subcommittee of three Board members (Diana Kent, Bill Maes and Dorothy Fitzgerald) was established to begin the process.

The subcommittee adopted a strategic planning model which recommends four basic steps: establish a mission statement; assess your strengths and weaknesses; decide where you want to go; and decide how to get there. At the Board meeting held in Montreal on 18 June 1986, the following was accepted as a working definition of the CHLA mission statement:

> "The mission of the Canadian Health Libraries Association is to improve health and health care by promoting excellence in access to information."

Based on the valuable input from the chapters, the subcommittee of three also reviewed the strengths and weaknesses of the association for the entire Board and recommended that priorities be set for further action in the planning process. At this point, the Strategic Planning Subcommittee was expanded to include all Board members and the November 1986 Board meeting was identified as the forum for detailed discussion of position papers on concerns of highest priority.

The position paper on association finances and the business aspects of running CHLA/ABSC was prepared by Bill Maes and Dorothy Fitzgerald. The recent increase in membership dues and the success of the Montreal conference allowed the discussion to focus on action which can now be taken to resolve some of our problems. Every consideration was given to establishing the association on a footing which will allow all members to give serious thought to running for a Board position. While each member is strongly encouraged to put her/his name forward for association positions, it is often academic centre librarians who take on these positions as they can -- more frequently it seems -- absorb the extra time and costs involved in association work. Most of our members are hospital librarians, however, and in this regard we are very fortunate to have Jan Greenwood as our President Elect. As the Ontario Medical Association Librarian, Jan's primary day-to-day concerns are those of hospital librarians throughout the province.

It was recognized that to encourage hospital librarians to become involved at the national level, a permanent CHLA/ABSC Secretariat would be necessary. To this end,

the Board approved the contracting out of selected association business tasks for a one year period, subject to review on a regular basis. The work to be contracted out will include such tasks as maintenance of the association membership records and upgrading the **CHLA/ABSC Directory**.

The Board also discussed the costs involved in taking on the position of Editor of **Bibliotheca Medica Canadiana**. Once again, these very considerable costs have often been absorbed by the institution of the Editor, thereby limiting the number of members who can, realistically, consider taking on this position. The Board approved the allocation of funds to the Editor for the production costs involved in editing our journal. This money might cover secretarial costs, telephone and electronic messaging costs, and any other similar costs.

Hanna Waluzyniec, Membership Chair of the association, prepared a background paper on marketing and public relations. It was emphasized that CHLA should first establish a target market (both in terms of membership recruitment and publicity for the association) and should then choose an initial marketing project which would have a high impact on the organization for a relatively small cost, in a reasonably short period of time. Various initial marketing projects were considered, including the development of an exhibit for the 1987 conference of the Canadian Hospital Association. The Board approved follow up action on this initiative.

Ann Barrett, our Continuing Education Coordinator, presented a strategic plan for CHLA/ABSC Continuing Education. Based on our recent CE Needs Assessment Survey, Ann noted that preferred topics are: new technology, online searching, and automated systems. Major deterrents to our members are distance, lack of time and cost. Our major environmental influences regarding CE were identified as technological change, relationships with other health associations/organizations, and geographic considerations. This detailed strategic plan draws attention to a number of key issues and identifies a number of possible solutions. Issues raised and discussed include: the limitations of assigning the implementation of this task to a single coordinator, the importance of ongoing membership needs surveys, the development and distribution of Canadian CE materials, the need for a roster of Canadian CE courses and presenters, a regular CE column in **Bibliotheca Medica Canadiana**, financial support to the chapters from the national association, and communication with other health care associations regarding the importance of continuing education for health library workers. The Board approved follow up action on many of the recommendations made in the document.

While action is now being taken on many fronts as a result of these strategic planning documents and Board discussions, clearly a great deal more work is ahead of us. We will now be forwarding more detailed summaries of the position papers to the chapters and asking for feedback on progress to date and recommendations regarding the next stage in the strategic planning process.

* * * * * * * * * * * * * * * *

GREAT BEGINNINGS . . .

Ann Barrett

Interlibrary Loans Librarian
W.K. Kellogg Health Sciences Library
Dalhousie University
Halifax, Nova Scotia

Welcome, to the first Continuing Education page to be published in **Bibliotheca Medica Canadiana**. The goal of this page is to provide practical, timely and succinct information on topics of interest to many of our readers. Also, by providing a contact address for each contributor, readers will be able to pursue a topic in greater depth with a colleague who has first-hand information.

In the recent *Needs Assessment Survey* (**Bibliotheca Medica Canadiana** 1986; 8(2): 54-61), a regular CE column was listed as second on the list of desired continuing education initiatives. Having noted that, it must be said that although a column is easy enough to start, it will only be as successful as the membership make it; you must contribute your experience, knowledge, imagination and time !

This, then, is an open invitation to contributors. Please be generous with your expertise! If you have a topic that may be of interest to other readers of our journal, write about it! Your ideas and knowledge may help someone improve service, save time, save money, and the like. On the other hand, you may want to know about a topic and wish someone would write about it. Drop me a note; we'll round up a contributor.

Chapter Presidents will play an important role in identifying both contributors and future ideas for this page. I'll be in touch with each President in the near future and will keep up regular communication to get as much feedback as possible.

The position of Continuing Education Coordinator is very new in our association and is still developing. I encourage all members to review the Terms of Reference of the position (see next page) and to make your needs known by sending in the survey accompanying this issue.

I'm looking forward to your comments, ideas and support. See you in the next issue! Meanwhile, you can contact me at the following address:

Ann Barrett, CHLA CE Coordinator
W.K. Kellogg Health Sciences Library
Dalhousie University
Halifax, Nova Scotia B3H 4H7

Telephone: (902) 424-2469 Envoy 100: ILL.KELLOGG

* * * * * * * * * * * * * * *

TERMS OF REFERENCE: CONTINUING EDUCATION COORDINATOR

The Continuing Education Coordinator shall be concerned with all matters relating to education for health librarians, and library and information personnel who hold membership in CHLA.

The Coordinator shall be appointed for a 2 year term; will be responsible to the Board of Directors of CHLA; must report in writing at each board meeting; and must report annually in writing.

The CE Coordinator shall:

- Coordinate and recruit contributors for the CE Column in **Bibliotheca Medica Canadiana**
- Be available to assist and advise the local Conference Continuing Education Committee on budget, course content, certification and any other area of education for annual conferences
- Identify and initiate topics, developers, supervisors, and presenters for Canadian continuing education programs, and identify the best format for these programs.
- Maintain channels of communication with the education section of MLA and solicit certification of any programs presented by or for CHLA
- Identify education needs and concerns of the membership via annual polls of chapters
- Maintain a roster of persons interested in developing or presenting continuing education programs
- Maintain course materials and evaluations of all CHLA/ABSC courses and workshops
- Encourage the development of Canadian health education materials such as syllabi, manuals etc.
- Promote the education needs of the membership to other health care associations and organizations

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INFOHEALTH -- TO SUBSCRIBE OR NOT TO SUBSCRIBE . . .

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Infohealth is described by its creators, the Canadian Hospital Association (CHA), as "a comprehensive Canadian health care communications and information network". This represents an ideal -- what *Infohealth* would like, some day, to become. It is, unfortunately, not the actuality.

It is important to understand at the outset that *Infohealth* was created, and is being marketed, not as a library tool, but as a tool for health care executives and professionals (understand here physicians, perhaps some nurses, not librarians). As such, it seeks to provide services which, first of all, benefit and appeal to these groups directly. *Infohealth* appears at the moment to be only marginally interested in health libraries, insofar as this might help it to gain access to its primary market.

The Canadian Health Libraries Association (CHLA) has never really been opposed to what CHA is attempting to create through *Infohealth*. If it creates Canadian health databases, *Infohealth* will indeed be a valuable added service to the health care community. CHLA's objection was actually that *Infohealth* might be given exclusive responsibility for providing MEDLARS (Medical Literature Analysis and Retrieval System) services in Canada (now provided through CISTI), while its own viability remained unproven, and its commitment to the cause of health libraries was somewhat less than exemplary. Since CISTI has decided not to turn over to CHA and *Infohealth* the distribution of MEDLARS services in Canada, however, it should now be possible to consider the service, impartially, on its own merits.

SERVICES

At present, *Infohealth* offers electronic messaging, bulletin boards intended to fill the needs of health executives and professionals, and access to a large number of databases (approximately eighty) including Medline, through the facilities of the BRS Colleague system. Access to *Infoglobe's Health News*, *Marketfax*, a stock market quotations service, and *Official Airline Guides*, a worldwide flight and hotel reservation database, is also available.

Since *Infohealth* is a subset of the TransCanada Telephone System iNet gateway service, many of the features and databases are not exclusive to *Infohealth*. It has the potential, however, to provide exclusive features if it can afford to create Canadian health databases, and if it can obtain enough subscribers to make such features as executive and professional bulletin boards viable and valuable.

As an example, if enough health libraries or their institutions subscribed, CHLA could, conceivably, use the service to establish a bulletin board on *Infohealth* to

serve the needs of the health libraries community. Through electronic messaging, CHLA and CHLA chapters could keep in touch with their members and announce meetings, election results, and the like. The **CHLA Directory** might be mounted online and kept up-to-date on a weekly, or even daily, basis. A job board could be created where health information positions could be sought and advertised. The possibilities are almost endless.

Nevertheless, the problem remains -- unless *Infohealth* can obtain more subscribers, it cannot afford to develop its own databases and services which would make it unique and valuable to the health care community; and, unless *Infohealth* develops such services, its creators cannot expect to obtain more subscribers.

COSTS

Except for the initial sign-up fee of $250.00, and the somewhat higher than standard monthly fee of $12.00 for the initial password (additional passwords are available for $5.00 per month), the services provided by and through *Infohealth* are no more expensive than if one were to obtain these services directly from the producers. Medline on BRS Colleague, for example, costs approximately the same, whether one obtains a subscription through *Infohealth*, or enters into a separate contract with BRS.

It is true that Medline can be searched more cheaply if a contract is obtained through CISTI. As offered through CISTI, however, Medline is a command driven system, which can be considerably more difficult to use, and almost impossible for the casual searcher to use well -- i.e., the executive and health professionals at whom the *Infohealth* service is currently aimed.

The costs of the messaging service on *Infohealth* (and iNet) are time based, while the cost of the same service provided through ENVOY 100 is based on the number of characters sent and stored. In the latter instance, whether it takes two seconds or two hours to type a message, the cost will not vary. In the former, the cost of the same message could relate directly to the typing speed and skill of the sender. Sending longer reports or letters could be much less expensive on *Infohealth* (or iNet), however, since it is possible to compose the message offline and upload it into the messaging service. It is possible to upload and send a 10,000 word report relatively inexpensively in a matter of minutes on a time based system, while on ENVOY 100, one would be charged for each character sent, regardless of the time spent online -- a much more expensive proposition.

Cost considerations, then, do not provide a simple and straightforward means of making a decision about whether or not to recommend subscription to *Infohealth*.

FURTHER CONSIDERATIONS

Possible Advantages:

1. If a hospital or health care executive should choose to subscribe to *Infohealth*, for whatever reasons without regard to the librarian's concerns, an opportunity might, nonetheless, be provided for the library to

use some of the services and databases to which it would, otherwise, not have access.

2. Hospitals and health care executives in rural areas which do not have direct access to a Datapac telecommunications node are, presently, faced with paying expensive voice communications charges to send electronic messages and to use electronic database services. Both iNet and *Infohealth* provide 1-800 number service which allows communications at the data rate--approximately 1/3 the cost of the voice rate.

3. *Infohealth* does offer some exclusive services. Unfortunately, at the moment, none of these is aimed at libraries.

4. *Infohealth* offers unified billing, regardless of the different databases and services used. This could save accounting headaches.

5. Because it is menu driven, the system is relatively easy to use.

Possible Disadvantages:

1. *Infohealth* customer support still appears to be very weak. In Alberta and British Columbia, and probably in other provinces, the system is marketed through the local telephone network. Hence, service depends on the telephone system. CHA direct support still needs substantial improvement.

2. It is not clear at this time whether *Infohealth* will be able to survive beyond a few years if it does not obtain more subscribers.

3. *Infohealth*'s advertising oversimplifies the complexities of electronic messaging and database searching.

4. The value of the system rests, to a great extent, in its potential: in its ability, eventually, to provide Canadian health databases, more health information services, and in linking a substantially increased number of subscribers.

To subscribe to *Infohealth* (or to recommend that your institution subscribe) is a decision which must be made within the context of the institution itself, considering its own very special needs. The fact that the health library staff in the academic health centre searches Medline directly (through its contract with CISTI) because it is cheaper, and possibly, more efficient, does not mean that this choice is also the best for the rural hospital library staff who are actually casual users. In reaching a decision, you must consider your needs, those of your institution, and the alternatives to subscribing to any electronic services at all.

Hopefully, *Infohealth* can succeed in its mission -- the creation of a comprehensive Canadian health care communications and information network -- for the success will be of great benefit to us all.

THE MCGILL UNIVERSITY / CHINA MEDICAL UNIVERSITY LIBRARY COOPERATION PROJECT : A PRELIMINARY REPORT

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In 1985, a decision was made to form links between the McGill University Medical Library and the Library of the China Medical University, in Shenyang, People's Republic of China. It was assumed that these arrangements would lead to cooperation in interlibrary loans, acquisitions, and in answering reference questions. The first (unexpected) result was that the author was invited to Shenyang in March and April 1986 to advise the Library of the China Medical University on improving their collections and services. The China Medical University agreed to pay expenses in China and travel grants were obtained from the Gouvernement de Québec and McGill International.

SITE REPORT

The China Medical University was founded in 1931 in Jiangxi and accompanied Mao Zedong on the "Long March". By 1945, it had moved to north eastern China, and in 1948 was amalgamated with two existing medical colleges in Shenyang: the Moukden Medical College (founded by the Scottish, Irish and Danish Protestant missions in Manchuria and opened in March 1912) and the South Manchuria Medical College (founded by the South Manchurian Railway Company, connected to Kyoto University and opened in 1911-1912).

The China Medical University is one of the 13 Chinese medical colleges funded directly by the Ministry of Health in Beijing. There are 126 medical schools in China; the others are funded by provincial and municipal governments and the army. The China Medical University offers a 5 year programme and has a total enrollment of about 2,200. The university is divided into 6 faculties: Medicine, Pediatrics, Nursing, Dentistry, Forensic Medicine and Hygiene. Each faculty has a dean who reports to the vice president of the university. The library is part of the "academic sector" and also reports to the vice president.

As a result of its long history, the advantage of having had three pre-existing collections on which to draw, and careful selection and management over the years, the journal collection at the China Medical University is excellent. The library currently receives over 1,400 serial titles (approximately half of which are in English; a further quarter are in Japanese) and there are 3,558 titles in the serial collection in total. For comparison, the McGill University Medical Library has 2,200 current titles, and 6,500 serial titles in total. The Project Director and the Director of the Library of the China Medical University are intending to examine extensively the overlaps and the coverage of their two collections over the next few months.

The non-Chinese language monograph collection at the China Medical University, though large, is not as current as is the serials collection. The university has

recently, however, received a World Bank loan and intends to use part of it to purchase foreign monographs. During the visit, a list of over 500 English language titles was examined. When purchased, these titles will greatly improve the foreign monograph collection of the library.

Apart from surveying the collection, the author spent a considerable amount of time during the visit in seminars with small groups of library staff. There were approximately 20 such sessions, dealing with almost all aspects of health library organization and management; they usually consisted of a discussion of how common library problems are handled at McGill, and an evaluation of the solution employed which examined the possibility of its usefulness at the China Medical University. Though it was expected that the basic library problems would be similar in the two institutions, it was also expected that the differences in social structure of Canada and China would bring to the fore different problems and solutions in areas such as management of personnel and financial controls. During the seminars, however, it became apparent that the similarities greatly outnumbered the differences, and the Chinese expressed considerable interest in such things as performance evaluation, rewards for exceptional performance, and the initial selection of staff.

The most interesting differences were in the related areas of staff numbers and salaries. Though at McGill, like other North American medical libraries, we would like to hire more library staff with strong subject backgrounds in medicine, the salary structure prevents our being able to attract such people. Only 2 of 7 librarians presently on staff in the McGill Medical Library have backgrounds in the life sciences (though almost all have several years of experience in biomedical libraries). At the library of the China Medical University, there are 18 staff equivalent to professional librarians in North America, and 5 of these also have M.D. degrees. This fortunate situation is the result of there being no salary differential between teaching academics and academic librarians; thus, it is easier to attract and to keep top class subject specialists in the library.

One desirable result of this subject expertise in the medical library, which is quite common in China, is the emphasis given to library and bibliographic instruction. In 1984, the Ministry of Education decreed that all medical universities must offer compulsory courses in medical bibliography and literature research. In addition to this course, the China Medical University hopes to get permission to establish a "major" in medical bibliography in 1986-1987. Graduates from this programme would be expected to work in health sciences libraries.

Another difference between the two libraries is the percentage of the budget each spends on salaries. At McGill, it is about 55%, while at the China Medical University Library, only about 17% of the total budget is spent on salaries. This is the result of comparatively lower salaries in China, generally. The China Medical University has 52 library staff while the McGill Medical Library has a staff of only 23.

In addition to the seminars and discussions, my hosts at the China Medical University arranged a series of visits to laboratories and hospital wards, to other libraries in Shenyang, and to several historic sites in Shenyang and the surrounding country. These arrangements were excellent and greatly added to the value and enjoyment of my visit.

RESULTS OF THE VISIT

The most concrete result of the visit was the signing of an agreement between McGill University and the China Medical University. The agreement deals with such things as interlibrary loan cooperation, mutual assistance in acquisitions and reference and, most importantly, the training of staff from Shenyang at McGill. This programme will require grant funds, but proposals are presently being formulated and will be discussed with the librarian at the China Medical University before being submitted. At present, we are working towards a programme which would bring five staff from the China Medical University Library to the McGill Medical Library for a six month "internship"; the programme would be spread over five years.

A further development is the opening of a dialogue between the vice presidents of McGill and the China Medical University which, we hope, will lead to cooperative projects at the university level and to further exchange of staff and students.

Progress in both of these programmes will be reported in future issues of this journal.

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IN SEARCH OF EXCELLENCE IN HEALTH CARE: LEGAL AND ETHICAL IMPERATIVES -- IMPEDIMENTS OR SAFEGUARDS ?

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Today, legal and ethical imperatives form part of the field of health care law and ethics. While law has always been applied to regulate medicine, and medicine has long referred to ethics, this is a new area as an organized, integrated and separate field of clinical and research activity. One anecdotal example of the extent of this development, which might be of particular interest to librarians, is that it is said that in 1970 there were approximately seven articles published in English in this field. In 1980, there were fourteen specialty journals and the growth rate has not decreased since then.

This development has largely been stimulated by changes in medicine, itself, including: changes in its practitioners; its patients; its institutions; its systems; its policies; and its politics. Until relatively recently, medicine had little power to do good, but it rarely was a cause of serious harm. This is no longer true; iatrogenic injury can be serious and is not uncommon. Technocratization and bureaucratization of medicine have made individual patients feel less able to control the application of medicine to them. Rather, medicine is seen as controlling them. This has a dehumanizing effect. Depersonalization of the medical relationship leads to the same outcome. Illness is frightening and fear is likely to be augmented, and certainly not ameliorated, in a depersonalized relationship. There has also been a change from paternalism to egalitarianism as the basis of the medical relationship which has benefits, the principle one being promotion of the "therapeutic alliance" between physician and patient. This change has altered the relative positions of power within the physician-patient relationship. One reflection of this is the now almost universal recognition of the necessity to respect patients' rights: for example, their right to autonomy which is implemented through application of the doctrine of "informed consent". An example of a more controversial right, in some circumstances, is that of access to medical care. Recognition of such rights is part of the development of the field of human rights in general. From yet another perspective, the fact that medicine has become a major industry and a high-level and extensive governmental activity has also changed its nature.

But, not only has there been change in medicine and health care professionals, there is also change in patients. The level of education of patients has increased

significantly. Patients want to know, and can understand, more. They are better informed than their forebears about medicine in general, because of the large amount of publicity medicine receives, especially from the media. And patients' expectations have increased, sometimes to unrealistic levels. In this latter respect, much greater care needs to be taken. To disappoint a patient's expectations is to harm him or her and medicine's aim, as always, must be "first do no harm" (*primum non nocere*). Disappointed expectations on the patient's part may also harm the physician. Such patients can become angry and hostile, and angry, hostile patients are usually the ones who sue for medical malpractice.

Unrealistic expectations on the part of patients may be linked with the characterization of medicine as "modern miracle medicine". This, in turn, is linked with a societal phenomenon in which medicine has taken over some of the functions of religion and even replaced it. It may be that with declining numbers of persons believing in an after-life, there is an increased impetus to make this life as "immortal" as possible and medicine is the societal institution which promises the most in this respect.

Other factors which have caused change in medicine include decrease in respect for the professions, in general, and their practitioners. This is clearly due to multiple factors, including: that the professions have been relatively demystified with a higher level of education of the population in general; that access to membership in the professions is, on the whole, open to all levels of society; that the behaviour of some professionals individually, or as groups, has caused a loss of respect; and that the intense specialization undertaken by many professionals can leave them appearing to be, or in fact, largely ignorant outside their narrow area of expertise. If such persons were compared with the broadly educated professionals of the past and each of these were compared with their non-professional contemporaries, modern professionals may well have a more difficult task than their historical counterparts, in gaining respect. Within a related range of considerations, changes in notions of authority, and in concepts of individual rights, can be examined and the changes these have wrought in society and in medicine can be traced.

Challenges to regulation of medicine by the profession (self-regulation) are also a relevant factor in examining the effect of health care law and ethics on medicine and in assessing whether these are impediments or safeguards, because law and ethics are often used as the tools of such challenges. Challenges can be by <u>other professions</u> seeking power. These may be covert challenges, for example, nurses acting as advocates for patients' rights, both because they believe in the cause and because they wish to challenge the power and authority of medicine and its practitioners. Activism by nurses in these regards may also be a challenge to sexism, in that traditionally, medicine was predominantly male staffed and dominated, and nursing, female staffed and largely controlled by medicine and, therefore, male dominated. Challenges to medicine can also be by <u>governments</u> who pay the bill. For example, the recent Ontario "doctors' strike" was a reaction to the Government controlling the income of medical practitioners, and saving money for the community and patients, by prohibiting "extra billing". Dissatisfied <u>patients</u> who take malpractice actions in the courts can also be regarded as challenging medicine and, indeed, they often articulate that they feel that this is what they are doing.

Another challenge to self-regulation by medicine can be mounted through analysis of the basis on which medicine claims to be entitled to use this form of regulation.

This is founded, first, as Katz explains[1], on the concept that medicine consists of a body of esoteric knowledge that cannot be understood by "lay persons", which is a term worth noting. It can be pejorative, and is certainly de-professionalising of non-physicians. Happily, it is now used much less often, which may well reflect a recognition that persons other than physicians, including other professionals, may well have a valid input and perspective unable to be supplied by physicians in "decision-making in a medical context". This form of decision-making should be compared with "medical decision-making". The former has a broad, multidisciplinary fact and value base. The latter is purely medical. Self-regulation by medicine is also argued on the basis that the institution of medicine can be trusted because its fundamental guiding principle is altruism. Neither of these claims are any longer perceived to be necessarily true. But this does not mean that we should immediately act to control medicine from the outside to any greater degree than we do at present. The principle of "the least restrictive, least invasive alternative reasonably available and likely to be effective" is as applicable here as it is in many other issues in health care law and ethics. We must tread carefully in any legislative or legal intervention to regulate medicine, if we are not to risk becoming bulls in china shops.

Like the use of medicine, the use of law can be beneficial and the intention is to confer benefit. But law is not harmless; and law is also an experiment -- a social experiment -- especially in regulating new areas of medicine.

New law is perceived as being needed to regulate medicine when, first, it is thought that there are new developments, which are not contemplated by any existing law, that is, there is a vacuum and there is concern or fear regarding the conduct that might take place in that vacuum. Reproduction technology, for example, the creation of "test tube" babies, is such a development. Second, new law will be seen as needed when present law is perceived as out-of-date or unable to cope with new scientific or medical developments.

It should be kept in mind that usually the issue is not whether law is to be used to govern medicine, but whether to enact special laws to do this. Medicine, like all other activities in our community, is governed by the general law. For example, surgery is *prima facie* a crime because it constitutes intentional infliction of bodily harm, but this becomes justified when it is performed with reasonable skill and care, for an acceptable purpose, and with consent. In deciding whether we need special laws dealing just with medicine, or some particular aspects of it, we should note that in an "open legal system" (which applies in Canada) all conduct which is not prohibited is permitted, consequently, laws are more likely to be seen as necessary to prohibit certain conduct than to permit it.

But law is not only prohibitive, it may also be neutral, enabling, or promotive of certain conduct. Sometimes we may want to make certain conduct mandatory. One area where this is likely to be important in relation to medicine is in providing rights of access to medical care, which will constitute an increasingly contentious, disruptive and difficult issue, creating serious conflicts in our societies. The form that any such rights take will need careful consideration, analysis and nuance.

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1 Katz J. **The silent world of doctor and patient.** Yale, New Haven: Free Press: 1985.

For example, there could be a difference in outcome between prohibiting a physician or hospital from denying medical care and requiring them to provide access. In the former case, it may be possible to avoid breach of a legal obligation by refusing to enter a treatment relationship with the prospective patient. This would not be a defence in the latter case, although impossibility to perform the duty because of totally inadequate provision of resources by the government, might be.

We also need to keep in mind that law operates not only at a conscious level, but also that it has unconscious origins and symbolic functions. The law governing health care is no exception in this regard; in fact, it creates symbolism that has impact well beyond the health care arena. It may even be that the area of health care has very important symbolism carrying functions for our society in general. It carries, for instance, the symbolism of caring, of helping those in need, and of willingness to act to relieve suffering. It also contributes in a major way to establishing the ethical tone of the society in which it applies. This tone, it has been suggested, can best be judged according to how we treat our weakest and most in need members.

I would now like to examine some specific examples of legal or ethical interventions that may be characterized as either impediments or safeguards to achieving excellence in health care, and some areas of health care which have been subject to legal or ethical interventions, to explore whether these were impediments to excellence or necessary safeguards. But first, the concept of *excellence*, itself, merits some consideration.

WHAT IS EXCELLENCE?

First, we need to recognize that what constitutes excellence in a given respect or situation is a value judgement, which can be based on various possible combinations of subjective and objective assessment. This is obvious, but it is not always kept in mind and it can be important to do so. What may appear to be "excellence in health care" to a provider may be assessed as grossly defective by a patient. Consequently, relevant questions are: who decides what is excellent? on what basis? (that is, according to which criteria?) and by what decision-making process? In short, we need, first, to recognize that what constitutes excellence is not necessarily obvious "on the face of" a given set of circumstances and, second, to define, rather precisely, what we are in search of, when we are in search of excellence. It is suggested that what we should be seeking is to provide the best possible standard of scientific and technological medical treatment delivered in a humane and caring manner. That is, excellence is to offer the best of the "new" and "old" medicine (its science and its art) in a truly integrated form.

It is important to recognize that the type of integration contemplated above does not just occur spontaneously. It is a third order process that must be carried out after the science and art of medicine, the first and second order processes (or second and first order processes, respectively, depending on one's view, which is a matter worth debating because such characterizations are not neutral in effect) have taken place. It is tentatively proposed that much of the lack of excellence in modern health care is due to the failure to undertake this integrative process which leaves

the patient with the impression that he or she has received only the science or the art of medicine (usually the former), but not both. It is interesting to contemplate what role medical libraries and librarians could play in promoting this integrative process; to do so would certainly be a worthy cause.

The mind/body dichotomy has beleaguered medicine since it was introduced to reassure the Church that medicine was not treading on the Church's territory. The Church could remain custodian of the important part of the person -- the immortal soul -- while medicine interested itself only in the mortal body. The residue of this dichotomy may cause us to look for excellence in medicine only with respect to treatment of persons' bodies and not also in regard to their psyches. This is undesirable for reasons which are other than scientific, but, it may also be scientifically unsound. It is increasingly recognized that the mind-body nexus is mediated through neural-hormonal-biological mechanisms, that is, a person's psyche may inhibit or promote physiological processes and *vice versa*. For instance, the immune system can be inhibited by stress, and avoiding this might be important in the treatment of some persons infected with the AIDS virus. In short, to act in medicine on the basis of a mind/body dichotomy may not allow persons to activate their full range of self-healing mechanisms, or may inhibit these.

There is a trite old saying that "the operation was a success, but unfortunately, the patient died," which often could be modified today to "the technology was perfect, but unfortunately the patient did not feel cared-for and, therefore, was unable to activate his or her own self-healing mechanisms." Such mechanisms represent the true "placebo effect" of medicine and are no less needed today than in the past. The false "placebo effect" is that mediated by deception on the part of health care professionals, the use of which, fortunately, is being recognized more and more, as unfortunate.

INFORMED CONSENT

This leads to the doctrine of "informed consent", the legal and ethical requirement that patients be given all material information (which includes consequences and risks of proposed medical treatment and its alternatives, including the option of forgoing all treatment) and that the patient freely consents to the course of action undertaken.

It may seem paradoxical, but it could be that healing is achieved, and iatrogenic illness is avoided, through the requirement of the doctrine of informed consent that the physician share with the patient information on uncertainty with respect to treatment and the patient's situation. These outcomes can result because exchange of such information prevents deception, or makes it unnecessary, and this promotes "earned" trust which requires true intimacy, as opposed to "blind trust", which is founded on paternalism and may involve deception or non-disclosure[2]. Thus, disclosure of uncertainty promotes the so-called "therapeutic alliance" between physician and patient which should augment the true placebo effect, that of self-

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[2] See Katz, *supra*.

healing. The issue of uncertainty is central to one of the paradoxes of modern medicine: the more we know, the more we know that we do not know; that is, the only thing of which we are certain, in some circumstances, is that we are uncertain.

Some physicians, and initially most of them, saw the legal and ethical requirement to obtain informed consent as an impediment to excellence in health care. But this may no longer be the case. Research on informed consent in the clinical setting has shown some surprising results, which have helped to change physicians' beliefs in this regard. For instance, a health care professional may not be able to avoid communicating uncertainty, simply by avoiding speaking of it. Uncertainty, and even more so deceit, can be communicated non-verbally and, therefore, it is better dealt with directly. Physicians are more comfortable with adopting a "wait and see" approach if they disclose uncertainty to the patient, and this can reduce the cost of medicine and the rate of iatrogenic illness.

Disclosure of uncertainty reduces unrealistic expectations and hence, disappointed expectations, which can give rise to the rupture of the physician-patient relationship. This can result in hostility on the patient's part, because the patient feels not only wrongfully injured, but also abandoned. Such hostility can be expressed in the form of a malpractice suit. In short, the requirement of informed consent to treatment, which includes a requirement of "informed refusal" of treatment, has sometimes been characterized as an impediment to excellence in health care, because it allows patients to refuse treatment that they are perceived as needing, or the disclosure requirements are seen as "upsetting" the patient with full explanation of the risks involved. But, in fact, obtaining informed consent can have the opposite effect, both in purely "scientific" terms of promoting healing, and, even more importantly, in terms of promoting the concept of the patient as a person and causing all medical care to be delivered from a humanitarian perspective.

It is relevant to note in these latter respects, that informed consent is a suffering reduction mechanism, because it helps to give patients a feeling of control over what happens to them and suffering can be experienced as a feeling of loss of control. To reduce suffering is the basic aim of medicine and of the discipline of health care, law and ethics and, to the degree that informed consent helps to achieve this outcome, it should be regarded as promoting excellence in health care. Jeremy Rifkin, in his book, **Algeny**, speaks of "the old Darwinian notion of 'survival of the fittest'...[being] replaced by 'survival of the best informed'"[3]. This same idea is one of those that underlie the doctrine of informed consent -- information gives power and control. That is, informed consent is a power-sharing mechanism and if it results in a decrease of iatrogenic illness or an increase in judicious use of necessary medical care, it, too, may be a survival mechanism.

MEDICAL RESEARCH

Human medical experimentation is another area in which some persons regard legal and ethical imperatives as inhibiting excellence in health care. In fact, much of

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[3] Rifkin J. **Algeny: a new word -- a new world.** New York: Penguin Books, Inc.: 1984, p. 221.

the original discussion leading to the development of the field of health care law and ethics as an organized discipline was concerned with human medical research. Many people are unaware how recent human medical research is, as a large scale, societal and often commercial, undertaking. The emergence of the "industrialized medical complex" has fostered this growth and now we even have research "plants", where healthy, volunteer human research subjects participate on a regular basis for remuneration. There is concern over this type of activity, because the symbolism and precedents set by such organized undertakings are different from those created by *ad hoc* participation in research as a subject, even if the spontaneity of volunteering in the latter case is more apparent than real. In this respect, one can compare the attitude of the law to individual crimes as compared with group or "gang" ones. The latter are seen as much more of a threat to society and, in fact, the crime of conspiracy consists of two or more individuals planning a crime, whereas an individual alone, making the same plans in the identical manner, could not be prosecuted short of an attempt to carry out the crime.

Concurrently with our concern with human medical experimentation, there has been large-scale protest against the use of animals in medical research and this is increasingly subject to more and more stringent laws. Even more than the regulation of human medical research, this is seen by some persons -- particularly some medical scientists -- as a serious and unreasonable impediment to progress in medical research. Opponents of animal research are just as adamant in the opposite direction.

One of the most controversial undertakings in the area of medical research currently is human embryo research. This controversy even relates to whether or not research on human subjects is involved or whether this is simply research on a unique form of human tissue. The debate is characterized by polarized views (which is not surprising when its relationship to abortion, which itself is highly controversial, is pointed out). Those supporting the need for human embryo research argue that "the product of conception", "the fertilized ovum" or "the pre-embryo" (all alternative, non-personhood attributing terms) is of human origin and may deserve special respect, but is not a person and need not be safeguarded and treated as such. They emphasize the benefits that such research promises, argue that it cannot be carried out in any other manner (although this is often simply asserted rather than demonstrated to any convincing degree), and that the harms or risks of harm are acceptable. To prohibit such research would, in these persons' view, be an unacceptable inhibition of the pursuit of scientific knowledge. In contrast, those persons opposing human embryo research see the embryo as a person and as deserving of the same rights and protections as all other members of the community. Certainly, they would not allow the embryo to be put at risk or deliberately destroyed for the benefit of others, no matter how much good in the form of advancement of scientific knowledge and use of this knowledge to relieve suffering from disease and illness was promised thereby.

It is not only the carrying out of human embryo research which is controversial, but also some applications of this research are subject to fierce debate. For instance, it can be used to choose the sex of one's children and could, possibly, allow men to bear babies. There will be many difficult issues raised by such possibilities, not only as to what would constitute excellence in health care in relation to them, but also, whether or not they constitute health care at all, or, indeed, even acceptable conduct.

TREATMENT OF TERMINALLY ILL PERSONS

Application of a technological imperative in medicine often leads to "bad" medical care in the sense of over-interventionist care. There may be failure to achieve excellence by doing either too little in some circumstances, or too much in other circumstances. The issue is both what we ought to do, and what we ought not to do in terms of treatment. There is no doubt that the availability of medical technology creates a pressure to use it, but, this impulse needs to be governed by the realization that, sometimes, such use will do more harm than good. This type of situation is particularly likely to arise in relation to terminally ill persons, although there is now greater sensitivity to the need to accept that there may be more we can do in terms of interventions, than we should do. Such interventions are sometimes described as those which merely "prolong dying", which are to be compared with those which "prolong living", which it is a fundamental aim of medicine to achieve.

Important concepts of health care law and ethics in this area include the notion that over-treatment can constitute medical malpractice and recognition of competent patients' rights to refuse treatment, including through such prospectively operating legal devices as the "living will" (the patient's directions concerning non-treatment in the event that he or she is terminally ill and incompetent to decide at the time), and the "durable power of attorney" (the patient appoints a substitute decision-maker who is empowered to decide on medical treatment in the event of the patient's incompetence). Legal and ethical instruments of this nature can be characterized as safeguards against "non-excellence" arising from the very fact of administering certain medical care. That is, such laws provide protection against being treated when this would be invasive, disrespectful, or harmful to the patient.

ORGAN TRANSPLANTATION

What is excellence in health care in an area such as organ transplantation where: many procedures are experimental, but the alternative is death; the quality of the patient's life after the procedure may be poor; interventions are very expensive; there is a shortage of monetary and non-monetary resources (for example, human organs); and there are serious problems in finding an acceptable allocation mechanism? Is there excellence in health care when a programme to implant artificial hearts is undertaken primarily as a publicity-attracting campaign by a "for-profit" hospital chain, as has occurred in the United States? Is there excellence in health care when organs are allocated to dying children according to which parents are able to appear on television to appeal for an organ, or to persuade a public figure to do this? Does excellence in health care require fair and just decisions in the allocation of scarce medical resources? Is the excellence of health care affected by physicians and surgeons becoming "medical stars" as they have in the area of organ transplantation? On a more technical legal level, is the need for consent to the taking of organs contrary to technological excellence? Could we obtain more organs, in better condition, and better matched, if "contracting out" legislation were used; that is, if a presumption that organs could be taken unless the person, before death,

or the family, objected? Would any harm that such an approach generated be counted as a detraction from excellence in health care or is it extrinsic to this in that it may be harm, but not in the sense of detracting from excellence in health care? In other words, could one seek excellence in health care at the cost of some harm either to individuals other than patients or to the community, or would this be a detraction from the excellence sought?

AIDS

What is excellence in health care in dealing with an incurable, fatal disease? How can excellence be achieved when there is no "harm free" option available; for example, how can the rights and protection of individual "persons with AIDS" be balanced against rights and protection of the public?

AIDS raises many contentious issues in the areas of public health and preventive medicine and perceived conflict of community protection with individual rights. For instance, everybody could be screened for HIV antibody positivity, but this would involve serious harm both to some individuals and to wider values of the society. Likewise, failure to respect an individual's right to confidentiality may be thought necessary to prevent the spread of AIDS or to promote public health research. Even if this were true, there are serious harms inflicted by breach of confidentiality in the medical context. Moreover, failure to respect medical confidentiality many promote rather than inhibit, the spread of AIDS. This would be the case if such breaches cause people to be afraid of being tested for contact with the AIDS virus, especially persons who are members of high risk groups who engage in high risk behaviour and who therefore may transmit the AIDS virus. Failure to have an HIV antibody test may mean that these persons do not modify their behaviour whereas otherwise they would do so, either to avoid becoming infected or, if they are HIV antibody positive, to avoid infecting others or to avoid exposure to other infective agents which may be particularly dangerous to them because they have a damaged immune system. Without the test, a process of psychological denial may promote behaviour likely to spread AIDS in two ways: first, if persons are uncertain whether they are antibody negative, there is not as strong an incentive to avoid risk-taking situations in order to maintain this antibody status; second, persons who do not know for certain that they are antibody positive are likely to be less inhibited about engaging in conduct likely to pass on the AIDS virus.

AIDS raises a wide range of issues both inside and outside the health care context. The search for excellence in health care in relation to AIDS will raise many important issues, some of which will differ in extent or kind from those in other areas. AIDS will test our commitment as individuals and as a society to respect for human rights. It will challenge our concepts of fairness in allocating medical resources. AIDS will test our dedication to the aim of relief of suffering and our compassion. It will determine whether in practice, as compared with theory, we indeed have respect for <u>all</u> patients as persons and all aspects of their personhood, including their beliefs, values, attitudes and life-styles. In facing these issues our definition of what is excellence in health care is likely to be expanded and refined. That is, the categories of excellence are not closed and in pursuing

excellence it is essential to keep in mind that this is a continuing and dynamic process and not a static state which, once achieved, solves all present and future problems.

CONCLUSION

Each of the examples that has been examined in order to explore the concept of being "in search of excellence in health care" raises a different range of issues, only some of which have been identified in this discussion. But there are some common threads linking them. The examples make it clear, I suggest, that we cannot afford to pursue life-creating, or life-prolonging, or health-preserving, or disease-preventing technological interventions, on the basis only of the benefits promised, regardless of the costs in the broadest sense of that concept. Costs must be assessed in terms of lack of respect for individual rights; failure to care; suffering infliction; and lack of respect for persons. In some cases, the costs of providing or not providing certain treatments may be too great. It is the role of legal and ethical imperatives to strike the balance between costs and benefits in pursuit of excellence in health care. This means striking the balance, first, between the unbridled pursuit of excellence in the science of health care and reactionary positions which can reflect a fear of knowledge, because to pursue this is considered too "God-like". Second, it means striking the balance between purely scientific pursuits in medicine and its caring, humanistic functions, when these are not totally compatible. Sometimes, these are not easy balances to strike and are ones that need to be restruck continually, which makes them even more difficult and exacting. The challenge to health care, law and ethics is to become, as fully as possible, true safeguards of persons, principles, values and the fabric of our society in relation to taking the decisions that determine these balances. This does not mean that the role of health care, law and ethics is to safeguard the *status quo*; rather, it is to facilitate and accommodate necessary or desirable change, and to be as little as possible an unwarranted impediment. I have great hope that we will be able to achieve this and, with it, true excellence in health care, although I do not underestimate the difficulties that may often be involved.

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NCIP, CONSPECTUS METHODOLOGY, AND CANADIAN HEALTH SCIENCE COLLECTIONS

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At some time during the next two years, as part of their larger University libraries, most Canadian academic health science libraries will be evaluating their collections for inclusion in a continent-wide "conspectus" of research library collections. The purpose of this paper is to describe Canadian involvement in the North American Collections Inventory Project, the "conspectus methodology", and our experience at the University of Alberta with the Medical and Health Sciences section of the conspectus.

THE NORTH AMERICAN COLLECTIONS INVENTORY PROJECT AND THE CONSPECTUS

The North American Collections Inventory Project (NCIP) grew from the cooperative efforts of the Research Libraries Group (RLG) in the 1970's. The RLG is a partnership of the great American research libraries, formed in 1974 to meet cooperatively the combined challenges of fiscal uncertainty and exponential increases in the cost and volume of published information. But to plan the development of their collections, together, they needed a detailed overview. The instrument developed by Paul Mosher in 1979 for this purpose is the *RLG Conspectus*.

By listing together the comparative collection strengths and weaknesses of the participating libraries, the conspectus provides a broadly descriptive policy statement for the aggregate. According to Mosher, it breaks down "subject fields in such a way as to allow distributed collection responsibilities for as many fields as possible" and "reflects the distribution of collection strengths and collecting intensities in a way that can facilitate planning, but without the prescriptive implications of a 'policy'".[1]

The Association of Research Libraries (ARL) was quick to seize upon the potential of the conspectus as a means toward a much broader inventory of collection strengths beyond the RLG, which would, in turn, foster wider cooperative collection activities among ARL member libraries. In 1981-82 five non-RLG members, including the University of Manitoba Library, conducted a test of the conspectus as a framework for collection analysis. As a result, in 1983 the ARL endorsed implementation of the North American

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1 Gwinn NE, Mosher PH. *Coordinating collection development: The RLG Conspectus*. College and Research Libraries 1983; 44: 128-140.

Collections Inventory Project. A manual was developed and tested[2], training and documentation were provided, and beginning in 1985, ARL libraries throughout the U.S. and Canada began the task of "doing the conspectus".

Meanwhile, the RLG developed *RLG Conspectus Online*, an interactive database available on *RLIN* (Research Libraries Information Network); it is searchable by subject, institution, LC classification, collection levels, etc. As each section of the conspectus is completed by an institution, the results are entered on this database.

Having agreed to participate in mid-1985, the Canadian Association of Research Libraries (CARL) and the National Library of Canada are working collaboratively with the ARL on NCIP. Canadian involvement, in many ways, is the gateway to much broader international application of the conspectus and the Collections Inventory Project, as we develop language codes, translate the conspectus and training tools into French, and significantly revise many sections of the *RLG Conspectus* which have a marked U.S. bias. A *Canadian Conspectus Database* is also being developed, which will be available by spring of 1987. Thus, as Canadian libraries complete sections of the conspectus, the data will be entered onto both the *Canadian Conspectus Database* and the *RLG Conspectus Online*. The Canadian NCIP Coordinator is Mary Jane Starr, of the National Library of Canada.

CONSPECTUS METHODOLOGY

Conspectus methodology, quite simply, is a combination of collection-based assessment techniques (as opposed to user-based techniques), using standardized descriptors imposed on a uniform framework. Broad subject areas are subdivided on the basis of Library of Congress classification ranges. *Existing collection strength* (ECS) and *Current collection intensity* (CCI) are recorded for each line, on a scale of 0 to 5. RLG collection levels may be briefly defined as[3]:

0 *Out of Scope*. The library does not collect in this area.

1 *Minimal level*. Very basic works, and few of them.

2 *Basic Information level*. A highly selective collection "to introduce and define the subject and to indicate the varieties of information available elsewhere" not adequate to support advanced undergraduate or graduate study.

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2 Reed-Scott J. **Manual for the North American Inventory of Research Library Collections**. Washington, D.C.: Association of Research Libraries Office of Management Studies, 1985.

3 **Supplemental Guidelines for the Medical and Health Sciences Conspectus**. [Washington, D.C.: Association of Research Libraries Office of Management Studies, 1985].

3 *Instructional Support level.* A collection that could support undergraduate and most graduate study, and independent study. This would also represent a sound clinical support level in medical and health science collections.

4 *Research level.* Major published sources needed to support dissertations and independent research.

5 *Comprehensive.* Everything, published anywhere.

Language content is also indicated with a single letter code attached to the numeral indicating collection level (e.g., "3E" would indicate an instructional level, English language collection).

Collections are assessed according to four basic methods, ranging from objective to subjective, quantitative to qualitative: shelflist measures, used in comparison with other shelflist measures; bibliographic checking; shelf observation; expert consultation. Collections policies (provided that the institution has the resources to purchase what the collections policy registers the intention of purchasing) are also useful, as are approval plan profiles.

The problems implicit in these methods are the problems implicit in collection-based evaluation techniques in general. However, the need here is not to discover how well a given collection serves a library's constituents, but to determine what portion of the published "universe" of recorded knowledge in a specific subject a particular collection represents. The object is an overview, literally, a *conspectus*, of what exists in our collections, nationally and internationally.

THE CONSPECTUS IN MEDICAL AND HEALTH SCIENCES LIBRARIES

In the **Medical and Health Sciences Conspectus**, *Existing collection levels* and *Current collection intensities* are tested at 224 separate lines within 49 broader subject categories, such as *Cardiovascular System*, *Pediatrics*, *Nursing*, and *Physiology*. **Supplemental Guidelines for the Medical and Health Sciences Conspectus**[4] are available to provide some standardization. For example, the Brandon-Hill **Selected List of Books and Journals for the Small Medical Library** is suggested as a criterion for a level 2 collection. The **List of Journals Indexed for Index Medicus** provides a checklist for assessing periodical collections: 25 percent of all English-language journals is the minimum for a level 3 collection, while 65 percent of all appropriate journals in a subject area would constitute a level 4 or "research level" collection.

The *RLG Conspectus* is a developing instrument, an idea rather than the perfect realization, and so there are problems. With the **Medical Conspectus**, which we began in the summer of 1986 at the University of Alberta, we found difficulties in the work sheets themselves. Typographical errors in the class ranges, and a lack of class ranges and definitions for some lines necessitated close editing.

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4 *Ibid.*

While it is helpful to have both LC and NLM class ranges provided in the conspectus, frequently they do not precisely reflect the same subjects. Since we searched the MEDLARS Catline database on class numbers to derive a comparison shelflist and a "universe" against which to test our LC-classed monographic holdings (Brandon-Hill being too basic for level 3 and 4 collections), it was necessary for us to assure agreement between the two schedules.

Periodicals form the heart of a research collection in the health sciences library, and one of the chief criticisms of the conspectus methodology is that it is inappropriate for serials-intensive collections. To make matters worse, most health science libraries prefer to leave their journals unclassified and shelved by title. Shelflist measures and shelf observations cannot be used in this case, and list-checking, as advocated in the **Guidelines**, indicates the breadth but not the depth of periodical collections. Here, as in other applications of the conspectus methodology, one is best advised to fall back on expert knowledge -- frequently, one's own.

The question of what "universe" is an appropriate measure against which to compare one's collection is a difficult problem. Apart from topics in the history of medicine, which are well-represented in the **Medical Conspectus**, there are no standard medical or health science bibliographies for monographs at the research or even at the instructional collection levels. Catline provides the best facsimile universe, and can be tailored to the lines of the conspectus, but is costly to use and, like the **List of Journals Indexed for Index Medicus**, reflects an American bias. The **Library of Congress Shelf List** is inappropriate for medicine, because of the collection policy of that library. The **National Shelflist Count** is dated and not sufficiently finely broken down. To select an appropriate "universe", again, one must follow the **Guidelines** as far as they go and then fall back on some expert opinion or professional judgement. Validation studies which are a part of the conspectus methodology and which would support (or bring into question) those professional judgements are not yet available for the **Medical and Health Sciences Conspectus**.

The object of the conspectus methodology is to provide a common framework to describe our collections and to tell us locally, regionally, nationally, and internationally the shape of our aggregate collections, their strengths and their weaknesses. The most important use of the inventory we are helping to produce will be its function in planning together the development and preservation of our collections at a time when no single library can afford to be self-sufficient.

To be sure, there are costs to participating in the NCIP, mostly in staff time. There are methodological difficulties and inconsistencies, but these can be remedied quite simply if we agree to share our problems, solutions, and results.

From our work on the **Medical and Health Sciences Conspectus** at the University of Alberta, we feel that the conspectus methodology provides a valid collection-based assessment instrument for these subjects. While acknowledging the problems inherent in the **Medical Conspectus**, we feel it provides a useful standard format that can give us an excellent overview of the aggregate of our collections, while providing significant benefits to our individual libraries, now and in the future.

VENDOR ANALYSIS: AN OVERVIEW

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INTRODUCTION

As library budgets continue to decrease in terms of both absolute and relative buying power, how and where any library spends its funds is becoming of increasing importance. Although serials vendors will be emphasized in this discussion, observations made can be generalized to include any library vendor.

In the **Shorter Oxford English Dictionary** a vendor is defined as "one who disposes of a thing by sale; a seller".[1] However, the meaning of this term is augmented in the context of libraries where vendors are used to expedite the acquisition of materials for the collection. In a library setting, the three main uses of a vendor or agent are:

1) To act as a single source for publications
2) To provide standard invoicing
3) To provide service

Although it is not disputed that these are useful functions, the price paid by libraries for these services has risen substantially in the last few years. Librarians must decide how necessary vendors, and the services they provide, really are to the smooth functioning of their libraries. An outline of the reasons vendors are used by libraries, selection criteria which should be applied in selecting a vendor, and methods of evaluating one's prospective and present-day vendors will be discussed. Alternatives to using a vendor will also be presented for consideration.

COST CONSIDERATIONS

The factor which has most drastically affected the library/vendor relationship is the continuing decline of the size of dealers' discounts offered by publishing houses. At one time, this discount enabled agents to sell their services to libraries for a nominal fee since the majority of the agent's profit was realized from the difference between the price paid by the agent to the publisher and the price paid to the agent by the library. Libraries benefitted from this arrangement since the dealers' discounts were substantial enough to allow vendors to charge the library a lower price than the library would have incurred by dealing directly with the publisher.

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1 **Shorter Oxford English Dictionary**. Onions CT (ed.). Oxford: Clarendon Press, 1975.

This situation has changed dramatically, however, in recent years with publishers wooing libraries directly rather than through agents. The increasing use of computerization by publishing houses in areas such as accounting and billing procedures has allowed the publisher to prepare itemized invoices for all customers regardless of their size. Previously, publishers would only provide detailed invoices for their large, centralized customers (such as vendors) because of the time and expense involved. Since this discount, to a large extent, subsidized the vendor's cost of business, the vendor has had to look elsewhere in order to sustain his business as a profitable enterprise.

Librarians will agree, I think, that the vendor's cost of business seems to be, increasingly, paid by the library; this change is evident in the increased service charges. Fee-setting by agents can appear arbitrary, particularly when the service charge is not specifically identified or is applied to each title on an individual basis, according to some esoteric formula.

In addition to these obvious costs, vendors can also be expensive in terms of their delays in instituting new subscriptions and in responding to problems. Some libraries complain that vendors do not pursue their claims vigorously and that special supplements are often missed because the vendors are not aware of their existence. It appears that in the present economic climate, publishers prefer to advertize directly to the customer via specialty journals rather than through the agents.

SELECTION CRITERIA

As in locating a good plumber or electrician, the best guide to a high-quality agent is a satisfied customer. When selecting a vendor, one should contact libraries which are similar to one's own in size and scope in order to discover which agents offer the most satisfactory types and range of services. Useful information can also be gleaned from both the vendor and the satisfied customer by extracting answers to the following questions:

1) Does the vendor provide fast service in resolving problems? In processing claims?
2) Are accounting reports available on a regular basis? (Quarterly reports will permit the library to keep better records.)
3) Does the agent offer a stolen issue replacement service? What is the policy regarding issues which were not received?
4) How quickly are journal issues received? (This is especially important in the sciences where journals are the chief disseminators of information.)
5) Are there particular vendors who specialize in certain subject areas? How does their response/receipt time compare with broader-based vendors?
6) How comprehensive is the vendor's stock? Will the agent be able to supply most of the materials required from his own stock or will he have to "contract out" some titles, thereby losing direct control?
7) How useful and knowledgeable are the agent's representatives?

The answers to these and to similar questions can be useful only if the librarian has a clear idea of the objectives of the library and of what the library requires of

a vendor. Each library will have its own unique ranking system since the weighting attached to the objectives will vary as dictated by the internal and external environments of each library. Libraries which suffer from severe under-funding will rank cost as a more important consideration than availability, while other less severely constrained libraries will rank the quality and frequency of accounting records higher than cost of subscriptions.

In determining the objectives and their rankings, the objectives of each section of the library must be considered; it is unlikely that the objectives of each section or department in the library will be the same. For example, Technical Services staff may place the highest value on a vendor's quick response to claims; Public Services staff may be more interested in rapid delivery; while Administration may feel that overall cost should be the prime factor in determining which vendor to use. These objectives must all be reconciled and a ranking must be devised which is acceptable to all. It is important that the needs of the library as a whole be matched against the services offered by the vendor, rather than *vice versa*.

Some libraries may be too small to warrant the cost of using a vendor to maintain their serials collection. The benchmark figure is commonly acknowledged to be one hundred (100) titles; if the library subscribes to any fewer, it is more cost-effective to deal directly with the publisher[2]. Also, using a vendor does not ensure good service; as in any other business, vendors vary in the prices they charge and in the quality and quantity of services they provide for that charge.

Most libraries select vendors for the long-term. It is interesting to note that very few libraries consider changing vendors unless there is gross inefficiency or mismanagement of the account. Most library personnel responsible for serials administration exercise management by crisis in vendor control since they have little time to review a vendor's performance systematically until a service breakdown occurs[3]. While many librarians are willing to change vendors if the service deteriorates, few change vendors because of price increases, since it is felt that if one vendor raises prices, the others will soon follow suit. It is debateable whether this is, in fact, the case. However, changing vendors is a major undertaking and the cost incurred in transferring an account could well be greater than the increase in prices charged by the current vendor.

Librarians also seem to be unwilling to change vendors for a number of other reasons including tradition, reluctance to offend an agent with whom one has a long-standing and comfortable relationship, the complacency which can be engendered by such a comfortable relationship and other intangible factors. While these factors are certainly important in fostering a good working relationship between the vendor and the library, the fiscal health of the library must also be weighed against the quality of service provided by the vendor.

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2 Katz B, Gellatly P. **Guide to magazine and serial agents**. London, RR. Bowker, 1975.

3 Bonk SC. *Toward a methodology of evaluating serials vendors*. **Library Acquisitions: Practice and Theory** 1985; 9: 51-60.

The size of the agency is an important consideration in selecting a vendor. It is misleading to look only at the number of services offered; many of them will not be useful to the small or medium-sized library. One should ensure that the services which are required to meet the needs of the library and its objectives are easily available. While smaller agents may be cheaper because of their lower overhead, their correspondingly smaller range of publications and services may make them unsuitable. Once the field of choice has been narrowed, a price quotation should be requested from each vendor selected. The usual method is to submit the list of titles which the library would like the vendor to manage and to ask for an estimate of the costs which would be involved in administering the list. The quotations returned will vary in format and detail, but agents' representatives are usually quite willing to answer any questions arising. If the representatives are not approachable or easily contacted, however, that too is indicative of the type of service you can expect.

EVALUATION CRITERIA

Evaluating a vendor, whether it is one the library is currently dealing with, or one being considered, is a monumental task. For this reason, vendor evaluation is not often performed in smaller libraries. However, if the objectives of the library were determined and ranked before selecting the vendor, the task would be easier since concrete, specified criteria would exist against which the vendor's performance can be measured. It must be noted in evaluating a service -- and service is the primary function of the vendor -- that one is evaluating an intangible factor. Subjective judgement on the part of the evaluators may bias the evaluation to some degree. Those responsible for vendor evaluation must make some attempt to quantify their rankings (e.g., how fast is "fast enough ": one week or three?). Vendor evaluation should also be a time for reviewing the needs and objectives of the library and the scope of the collection, as well. It is possible that the reasons for which the vendor was first used are no longer applicable. The vendor's policies regarding pricing and services -- past, present and projected -- should also be examined.

If a decision is made to discontinue working with a specific vendor, consideration must be given to the timing of this decision. It is usually least disruptive to make such a change when titles are to be renewed rather than in the middle of the term of the order. Although librarians may be understandably reluctant to discontinue a long-standing relationship, maintaining such a relationship when major problems exist in managing the accounts will not be beneficial to either party.

ALTERNATIVES

Certainly, vendors perform useful functions in the library setting if they perform those functions which the library is unwilling or unable to perform. However, the costliness of vendor services must be considered in light of the present economic state of most libraries. In spite of the numerous disadvantages of vendors, surprisingly few libraries deal directly with publishers. While many librarians cite the amount of staff time involved in direct dealings with publishers as a reason for not dealing directly, it is my opinion that this option requires closer study. The cost/benefit ratio regarding agent versus no-agent serials acquisition needs documentation.

It is important that decisions of this sort be made on a factual basis rather than because of tradition or as a knee-jerk reaction to untried options. How much more time-consuming, in fact, would it be for serials staff to write directly to the publisher, rather than to the agent, to claim lost issues? Studies have actually found that direct order claims are more effective than those presented by a vendor on behalf of the library[4]. How much more expensive would it be to discontinue a vendor's services (and his service charges) and to hire additional staff to enable the serials department to deal directly with publishers and their invoices?

A major disadvantage cited in the literature concerning dealing directly with publishers is the number of cheques which a library would have to write and the expense resulting from this activity[5]. In fact, how many libraries actually bear the cost of writing cheques ? In most institutions, the cost of cheque writing is borne by the accounting department. Admittedly, one's administrators may not be keen to issue ten cheques where, previously, one sufficed but if a vendor is used in order to streamline the accounting procedures, one's administration should be made aware of this fact.

CONCLUSION

In the final analysis, librarians must decide what is best for their own situation with respect to vendor services. The changing environment in which the library functions and the increasing use of computers both by the library and by publishers requires that librarians re-evaluate their use of vendors. As the cost of subscription services increase, more thorough study of the alternatives available becomes more important. While it is appreciated that the idea of "going direct" may be anathema to many librarians, it should be given careful consideration. Dismissing an option that may prove to be both cost effective and an improvement in the quality of service offered to users of the library is no longer possible.

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I would like to thank Dan Heino (Information Services Librarian, HSL) and Gail Moores (Head, Technical Services, HSL) for their willingness to review and critique this article. The author retains full responsibility, however, for the ideas expressed.

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4 Itner SS. *Choosing and using subscription agents in sci-tech libraries: theory and practice*. **Science and Technology Libraries** 1983; 4: 31-42.

5 *Ibid.*

REDUCING THE CATALOGUING BURDEN IN THE SMALL HEALTH LIBRARY

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The single task which constantly threatens to overwhelm the majority of people working in small libraries is cataloguing the collection. For the trained, cataloguing can be an awesome task; for the untrained, it can be a nightmare. Indeed, on a recent consulting trip, I heard from one person who reported having dreams in which she was crushed by her backlog of uncatalogued books! At the Ontario Medical Association's most recent workshop on *Basic Skills for Hospital Library Personnel*, cataloguing was, as usual, identified as the matter of paramount concern to the participants.

Generally speaking, health sciences libraries do not catalogue journals, since they are readily self-sorting alphabetically by title, but all libraries do need to organize (catalogue) books and audio-visual materials in a way that will make them readily retrievable by subject, author (where applicable) and by title. The two inextricably related processes which allow such retrieval are known as cataloguing and classification.

WHAT IS DESCRIPTIVE CATALOGUING ?

Descriptive cataloguing tasks are those which describe the physical and bibliographic attributes of a work, no matter what its format, e.g. a book, video-tape. These attributes may be transmitted on to a catalogue or microfiche card, into a computer or other means for providing the library user with access to the contents of the library.

WHAT IS CLASSIFICATION?

Classification processes are those which enable one to identify a work's intellectual content and provide it with a unique call number or "address" on the shelves of the library. The term *call (or location) number*, which often appears on the spine of a library book, originates from a time when library stacks were not open to the general user and the number had to be "called" for retrieval by a staff member. In a library which employs a systematic classification scheme no two items will ever have the same call number.

Library materials can, of course, be organized (shelved) in a variety of ways: by subject, alphabetically by author or title, or even by size and colour! A subject class scheme however, is the most useful since it allows the user to browse the collection by topic of interest through its creation of subject "neighbourhoods" of

adjacent "addresses". The catalogue, on the other hand, enables the user to identify the location of items by a particular author or title.

The importance of using an established, published classification scheme cannot be over-emphasized: it ensures consistency in the use of subject headings and saves the individual library the time-consuming task of deciding what term to use to describe a particular subject concept, e.g. YOUTH rather than ADOLESCENCE. In most medical and health libraries the classification scheme of choice is that of the National Library of Medicine.

WHAT IS THE NATIONAL LIBRARY OF MEDICINE ?

The National Library of Medicine (NLM) is located in Bethesda, Maryland within a few miles of Washington D.C. and the Library of Congress (LC). It is the world's most comprehensive medical library and forms the pinnacle of a vast biomedical communications network within the U.S., but its impact is felt in Canada and beyond. In particular medical and health libraries are grateful to NLM for its computerized literature retrieval system, a collection of online databases known as MEDLARS (MEDical Literature Analysis and Retrieval System) and its classification system.

NLM's classification scheme provides an elegant and easy way to organize library materials and related sciences by subject. It employs the "QS-QZ" and "W" schedules which have been permanently excluded from the LC classification scheme and is thus compatible with that more comprehensive system. (This means, of course, that health libraries which contain non-medical titles in, say, psychology and sociology, may use, respectively, the appropriate "BF" and "H" schedules of the LC classification).

NLM provides health libraries with a variety of useful cataloguing products and services, including:

MEDICAL SUBJECT HEADINGS (MeSH)

Published annually, MeSH lists those subject terms and cross references which are used to classify citations contained in the major medical journal index published by NLM, namely **INDEX MEDICUS**. This subject heading list is the source for most of the subject headings which appear on catalogue cards in health libraries.

CATLINE

Access via computer terminal to CATLINE, a MEDLARS database which contains cataloguing information on a significant portion of the NLM collection. (Similarly AVLINE contains citations to audiovisual teaching packages which have been screened by NLM for technical quality).

CURRENT CATALOG

Published quarterly, **CURRENT CATALOG** is the print version of CATLINE and may be ordered on subscription.

NATIONAL LIBRARY OF MEDICINE CLASSIFICATION: A SCHEME FOR THE SHELF ARRANGEMENT OF BOOKS IN THE FIELD OF MEDICINE AND ITS RELATED SCIENCES

This publication is a comprehensive guide to assigning classification numbers in the medical and pre-clinical sciences.

Thus is NLM's vast store of cataloguing information available to health libraries anywhere through a variety of means: print publications may be obtained from the following address:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C., U.S.A. 20402

or indirectly from a local agent of U.S. government publications.

ORIGINAL AND DERIVED CATALOGUING

In most libraries, we have the choice of doing all of our own cataloguing or of purchasing or otherwise obtaining cataloguing copy from an outside source; the two are known, respectively, as *original* and *derived* cataloguing. The trick for the small library, especially, is to do as little original cataloguing as possible. Of course, in highly specialized libraries, or ones where local documents or unpublished materials predominate, it may be difficult to obtain derived cataloguing information, but in most small health libraries where general medical works prevail, there should be relatively few items for which original cataloguing has to be done.

WHERE TO OBTAIN DERIVED CATALOGUING INFORMATION

A variety of options is open to librarians who do not wish to do original cataloguing and the choice usually depends on such factors as the availability of a local library consortium, whether the library in question is computerized, and, of course, cost. Many libraries today retain their cataloguing information on computer and have the option of accessing major on line cataloguing systems such as UTLAS, but most small libraries still maintain a card catalogue. Libraries may obtain derived cataloguing information for which they must provide the actual cards, or may even purchase complete card sets.

A card set comprises all of the cards required to provide access to one bibliographic item: e.g. author, title and one or more subject heading cards. Many libraries retain also shelf list cards which are filed by call number, separately from the public card catalogue. A shelf list is an excellent inventory tool and may be used to record such information as purchasing details for future reference.

To conclude, then, here are some of the ways in which small health libraries can avoid or supplement original cataloguing:

1. Cataloguing information may be derived from such sources as have already been mentioned: CATLINE and AVLINE if they are locally accessible, or from the CURRENT CATALOG.

2. CATALOGUING-IN-PUBLICATION

A significant percentage of publishers now co-operate with LC and, where applicable, NLM in having cataloguing and classification information prepared before a book is actually published; this information thus appears in print, usually on the verso of the title page of a work, and is called Cataloguing-in-Publication.

NLM information appears in square brackets preceded by the designation "DNLM". In cases where the information has not been derived from NLM, the individual must use MESH and the NLM classification schedules to determine appropriate subject headings and class numbers.

3. CARD SETS

Complete card sets may be purchased directly from Marcive, Inc. (P.O. Box 47508, San Antonio, Texas 78265) or indirectly through a book agent (e.g. Rittenhouse). The price of a complete card set is currently approximately $1.25 U.S. and the turn-around time for response,allowing for the Canadian mail service, is about two weeks.

To ensure customer satisfaction the subscriber must, initially, complete a cataloguing profile form to determine exactly what is to appear on each card and in what format, e.g. NLM or Dewey Decimal class numbers; NLM or LC subject headings, where on the card the call number is to appear. Thereafter the subscriber simply submits, as needed, the ISBN (International Standard Book Number printed on the verso of title pages) or other identifying information and the cards are printed according to the previously established formula. (It is worth noting also that, at the same time and for a very modest sum, printed spine labels, book pockets and book cards may be purchased).

In seeking ways to reduce the cataloguing burden, small health libraries should not overlook the possibility of local assistance. Sometimes a well-established library will, for a modest fee, assume responsibility for acquiring and cataloguing the collection of another library. At the very least, these libraries will usually provide useful access to their own catalogues and cataloguing tools and, often, some moral support and advice!

FILLS TO BE TRIED OUT WITH ENVOY 100 AT EFAMOL LIBRARY

Christina Toplack

Research Librarian
Efamol Research Institute
Kentville, Nova Scotia

Interlibrary borrowing is a labour-intensive task and one is constantly looking for affordable methods of streamlining and automating as much of the work as possible. Electronic transmission (via ENVOY 100) of the bulk of our approximately 200 requests per week at the Efamol Research Library -- a two person, specialized, net borrowing operation -- has proven to be a valuable innovation. Furthermore, our recent purchase of a microcomputer (COMPAQ 286 Deskpro with a 30 MB hard drive) will permit investigation of interlibrary loans software, such as *Fast Interlibrary Loans and Statistics* (FILLS), developed by Rya Ben-Shir, Manager of the Health Science Resource Centre at the MacNeal Hospital in Berwyn, Illinois.

According to the literature on FILLS, it stands alone (no need for a database management system to run it) and is easy to use (intended for use both by clerks and professionals). The program is available on a single diskette for the IBM PC, XT, AT and M300 (the OCLC computer). It churns out requests on ALA-approved pin-fed forms, or can be used with *Easy Link*, a U.S. electronic mail system. The program compiles statistics and is programmed to produce reports such as numbers of requests per library, average return time per library, total and average costs charged per library; it will produce outstanding loan reports by patrons' names or by date of request, and will produce alphabetical lists of library addresses.[1]

As in other libraries, our present ILL procedures include the transcribing of verified requests onto proper request forms, checking against our own holdings, assigning of locations (if not held here), and the sending of requests via ENVOY 100 CAN/DOC or Canada Post to lending libraries. Upon receipt of the material, cost and item obtained are recorded. This requires the time-consuming maintenance of several paper files.

Though FILLS would not eliminate any of the steps detailed above, it would automatically maintain the pertinent files and would compile statistics which would save considerable time and work. All of this will only result in a net benefit in our setting if FILLS can be used with ENVOY 100; if it cannot, time saved on file maintenance, compiling statistics and printing forms will be lost on mailing them to

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1 Ben-Shir R. *Fast interlibrary loans and statistics: the second enhanced release*. **Library Software Review** 1985 May-June: 132-8.

libraries with which we now communicate via ENVOY 100. We would not consider using FILLS for non-ENVOY 100 libraries only as there are too few of them on our list of regular lenders to warrant buying special ILL software.

A query regarding the possible use of FILLS with ENVOY 100 (since it is used with *Easy Link* in the U.S.) directed to Ms Ben-Shir has resulted in an arrangement for the Efamol Library to test a version of FILLS with ENVOY 100. The software is expected in January 1987, and the trial will commence at that time.

The potential benefits of such a system are evident. Automating the interlibrary loans process and the cumbersome gathering of statistics that accompanies the process is the dream of every librarian with too much to do and too little time in which to do it! Report of the progress of the trial, once underway, will be forthcoming.

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CHLA ESTABLISHES TASK FORCE ON HOSPITAL LIBRARY STANDARDS

At its November meeting, the CHLA Board approved the establishment of a Task Force on Hospital Library Standards which will be chaired by President-Elect Jan Greenwood. Dorothy Fitzgerald, President, will also serve on the Task Force and regional representation has tentatively been established by appointing also Kathy Eagleton (Brandon), Verla Empey (Toronto) and Anitra Laycock (Halifax).

Ten years have now elapsed since the publication of **Canadian Standards for Hospital Libraries** and members of the Task Force will be most grateful for any support and advice that CHLA members can offer. Contact the chair of the Task Force on Hospital Library Standards at the following address:

Jan Greenwood, Chair
CHLA Task Force on Hospital Library Standards
Ontario Medical Association
250 Bloor Street East, Suite 600
Toronto, Ontario M4W 3P8

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CanHealth STILL AVAILABLE FROM CANADIAN LIBRARY ASSOCIATION

CanHealth: a guide for Canadian health libraries revises, updates and expands the *CanHealth* sections of **Bibliotheca Medica Canadiana** which appeared from 1982 through 1984. **CanHealth** is a useful source of Canadian information for those working in health sciences libraries; it contains a unique compilation of addresses and list of Canadian health reference tools.

103 pages. 1985. ISBN 0-9692171-0-2. Price $10.00

Send orders to: Publications
Canadian Library Association
200 Elgin Street, Suite 602
Ottawa, Ontario K2P 1L5

MARITIME HEALTH LIBRARIES ASSOCIATION MEETS IN MONCTON

The Maritime Health Libraries Association/Association des bibliothèques de la santé maritime (MHLA/ABSM) met in Moncton, New Brunswick on 3 October 1986. This was the first meeting ever held outside Nova Scotia. The name of the Nova Scotia Health Libraries Association was changed only in 1985 to reflect the long-standing inclusion of New Brunswick and Prince Edward Island members. The new executive remains heavily comprised of members from Nova Scotia, but there is now a liaison person from New Brunswick.

New Brunswick members supported the meeting with a good attendance; library personnel from hospitals and health libraries in St. John, Fredericton, Moncton and Oromocto were present. Susan Libby of the Moncton Hospital and Marthe Brideau of l'Hôpital Georges Dumont organized the proceedings. Included in the agenda was a report of the CHLA/ABSC 1988 Halifax Conference Planning Committee, which outlined the initial planning stages for the 1988 CHLA conference to be held in Halifax.

In addition to association business, there was a demonstration of a microcomputer library system being marketed by the Sydney Development Corporation, a Vancouver based company. Though expressly aimed at small libraries, this system appears to be capable of being used in libraries with larger collections also. The demonstration revealed the system to be highly developed for areas such as serials control, circulation, authority control, MARC record interface, and online public access catalogues. It seems, moreover, to be capable of a high degree of integration between these modules. The company offers full training and technical support and claims that improvements are continually being made in response to user recommendations. Those in attendance were impressed with the demonstration.

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PROMOTIONAL PAMPHLET BEING DESIGNED

The Maritime Health Libraries Association is designing a promotional pamphlet and would appreciate receiving examples of other chapters' pamphlets.

Please send to:

Christina Toplack, Research Librarian
Efamol Research Institute Library
P.O. Box 818
Kentville, Nova Scotia B4N 4H8

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ONTARIO HOSPITAL LIBRARY ASSOCIATION MEETS IN TORONTO

Margaret Taylor

Director of Library Services
Children's Hospital of Eastern Ontario
Ottawa, Ontario

The first annual meeting of the Ontario Hospital Libraries Association (OHLA) was held on 28 and 29 October at the Women's College Hospital in Toronto. Organizers were very pleased with the registration of 116; over half the current membership was in attendance and eleven of the twelve Ontario Hospital Association regions were represented.

The theme of the meeting was *Measuring Library Effectiveness*. We were fortunate to be able to include in the programme well-known speakers who are authorities in the fields of library and social science research. The keynote speaker was Margaret Beckman, Executive Director for Information Technology at the University of Guelph. Her topic was the political and financial importance of measuring library effectiveness. Professor Tom Wilson, Head of the Department of Information Studies at the University of Sheffield in England -- the next speaker -- chose research methods suitable for hospital libraries as his topic. He related these methods to Quality Assurance plans. The final morning speaker on the first day was Allen Gower, from the Questionnaire Design Resource Centre of Statistics Canada. Mr. Gower introduced the group to the "do's and don't's" of questionnaire design.

A brief business meeting was held before the luncheon and the executive all presented reports. Members of the current executive are: Verla Empey, President; Margaret Taylor, President-Elect; Don Hawryliuk, Treasurer; Linda Hill, Secretary; Susan Gillespie, Chair of the Education Committee; Jan Greenwood, Editor, OHLA Newsline; and Elizabeth Browne, Chair, Nominations Committee. Highlights of the business meeting included the announcement that OHLA was granted section status within the Ontario Hospital Association (OHA); the honorary life membership bestowed on Babs Flower for her work for hospital librarians in Ontario; and the introduction of two new members of the executive for the coming year: Christie MacMillan, President-Elect and Susan Hendricks, Editor.

The afternoon workshop was on Quality Assurance (QA). Linda McFarlane of the Sunnybrook Medical Centre introduced the key concepts and procedures of Quality Assurance. The group was then divided into two sections: one for those who had already done some work in developing a Quality Assurance plan for a library, and the second for those unfamiliar with the process. Sue Gillespie of the University Hospital, London, led the beginners' group, taking them through the steps in starting a Quality Assurance plan. She gave out samples of the QA forms she uses for reporting on audits of her library services and distributed handouts on QA terminology and readings.

Susan Hendricks of the Oshawa General Hospital was in charge of the "advanced" group which was divided into four discussion groups, each with its own facilitator. These groups discussed risk management, computerization and motivation as they relate

to QA. At the end of the afternoon, all the participants regrouped in the main lecture theatre to hear summaries of the two workshop sessions presented by Margaret Taylor and Tom Wilson, who had been acting as observers.

A series of tours and mini-clinics at four downtown Toronto hospitals (Queen Elizabeth, Mt. Sinai, Toronto General, and the Hospital for Sick Children) were offered on the programme of the second day of the conference. Over fifty OHLA members attended these tours. There were presentations on security systems, circulation procedures, collection development policies and current reference files. Tours were offered twice at each library to allow members to attend all four presentations.

Evaluations of the two-day meeting were very positive, with the morning session of the first day receiving the highest rating. Next year, as a section of the Ontario Hospital Association, OHLA will have its second annual meeting as a part of the 1987 OHA Annual Convention. (This year's meeting, although timed to coincide with the OHA Convention, could not be held at the Convention headquarters because OHLA was not then a section of OHA.) It is hoped that OHLA will also offer a continuing education workshop the day before or after the scheduled OHLA meeting. In the meantime, the executive are working on an exciting programme for the second annual meeting and are also busy preparing a programme for the joint OHA/OHLA workshop to be held at the OHA Headquarters in April 1987. The executive welcomes suggestions for future workshop and annual meeting themes.

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FROM THE HEALTH SCIENCES RESOURCE CENTRE

Marilyn Schafer

Head, Health Sciences Resource Centre
Canada Institute for Scientific and Technical Information
Ottawa, Ontario

IMPAG MEETING

The International MEDLARS Policy Advisory Group (IMPAG) met in 1986 at the National Library of Medicine (NLM) in Bethesda on 31 October and 1 November. All 16 of NLM's international partners were represented. This meeting is held every second year.

France, in particular, had two announcements to make. First, the French translation of MeSH, together with its corresponding PASCAL vocabulary, is now available in three volumes. The second announcement made by France was that Medline is now running on Télésystèmes and has a link via the CAS Registry Number to DARC, a database of chemical structures.

NLM also had several announcements to make. One concerned the development of MEDLARS III, which is now several years behind schedule. The delay occurred this year when it was discovered that, while the overall design of the system is good, as is that of three of the four modules in Phase I submitted by the contractor, one of those three cannot be executed. We were reminded, as well, that information retrieval is still in the third and final phase of the project.

NLM also announced that the second version of GRATEFUL MED is soon to be available. It will be on two floppy disks: one for the software, and the second for the MeSH. The software is being converted to C language from PL1 so that it will run on machines other than IBM's and IBM clones. The completion of this conversion is still about a year away.

Thirdly, NLM is also ready to make tape subsets available to Canadians as of 1 January 1987. At the moment, it is up to CISTI to work out suitable administrative procedures to handle payment, contracts and distribution. Contract holders will be subject to a strict quality assurance policy newly set by NLM.

HSRC ADVISORY COMMITTEE

The Health Sciences Resource Centre (HSRC) Advisory Committee met on 3 December 1986 at CISTI. This committee is an advisory body to the Director of CISTI, who sits on the committee *ex officio*. The Head of the HSRC is also a member of the committee, *ex officio*, and serves as its secretary.

Members are nominated by three associations: the Canadian Health Libraries Association (CHLA), the Special Resource Committee on Medical School Libraries of the Association of Canadian Medical Colleges (ACMC), and the Section de la santé de l'Association pour l'avancement des sciences et techniques de la documentation (ASTED).

Current members of the HSRC Advisory Committee and their terms of office are:

Anitra Laycock, CHLA	1983-1986	(Chairperson)
Louis-Luc Lecompte, ASTED	1983-1986	
Catherine Quinlan, ACMC	1986-1989	
Donna Dryden, CHLA	1986-1989	
Colin Hoare, CHLA	1986-1989	

The major topic of discussion at the meeting was the action to date on the recommendations contained in the joint ACMC/CHLA brief to CISTI, **The Role of the Health Sciences Resource Centre and Health Information Needs**. Full discussion of that document will appear in later issues of this journal, but many recommendations have already had some follow-up. Notable among these is the response of the National Science Film Library to the request that they purchase all NLM-produced videotapes (see the article by Heather Moore of the Canadian Film Institute in this issue).

Further follow-up to the brief is the action that caused the Head of the HSRC to become a member of the editorial board of the **CISTI News**; beginning with the issue for autumn 1986, there will be an item on the HSRC in each issue. As well, all libraries listed in the 3rd edition of **Health Sciences Information in Canada: Libraries** are on the mailing list for the **CISTI News**. We have chosen the **CISTI News** as the vehicle for spreading the word about the HSRC on the advice of the HSRC Advisory Committee, rather than starting yet another newsletter. To get on the mailing list, contact:

CISTI Publications Section
National Research Council of Canada
Ottawa, Ontario K1A 0S2

Telephone: (613) 993-3736
ENVOY 100: CISTI.PUBS

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DU CENTRE BIBLIOGRAPHIQUE DES SCIENCES DE LA SANTE

Marilyn Schafer

Chef, Centre bibliographique des sciences de la santé
Institut canadien de l'information scientifique et technique
Ottawa (Ontario)

REUNION DE L'IMPAG

L'International MEDLARS Policy Advisory Group (IMPAG) s'est réuni cette année à la National Library of Medicine (NLM) à Bethesda le 31 octobre et le 1er novembre 1986. Les 16 partenaires internationaux de la NLM étaient tous représentés. Cette réunion a lieu à tous les deux ans.

La France a annoncé premièrement que la version française du MeSH et du vocabulaire PASCAL correspondant est maintenant disponible en trois volumes. Deuxièmement, elle a annoncé qu'il est maintenant possible d'accéder au Medline par l'entremise de Télésystèmes et qu'on peut établir une liaison avec DARC, une base de données de structures de composés chimiques, au moyens de numéros d'inscription du CAS.

La NLM a également fait plusieurs annonces. La première portait sur la mise au point de MEDLARS III qui est maintenant en retard d'une à deux années. Le délai est survenu cette année lorsqu'on s'est aperçu que la conception du système dans son ensemble était bonne comme l'ont démontré 3 des 4 modules de la phase I soumise par le sous-traitant, mais l'un des trois modules ne peut être exécuté. On a souligné également que la recherche documentaire est encore la troisième et dernière phase du projet.

Deuxièmement, la NLM a annoncé que la 2e version de GRATEFUL MED devrait être bientôt offerte sur deux disquettes souples, l'une pour le logiciel et l'autre pour le MeSH. Au cours de la prochaine année, le logiciel sera converti du langage PL1 au langage C pour qu'il puisse à l'avenir être exécuté sur des machines autres que l'IBM et les machines compatibles avec l'IBM.

Troisièmement, la NLM pourra enregistrer, à compter de janvier 1987, des sous-ensembles des bandes magnétiques pour les Canadiens. Actuellement, il appartient à l'ICIST de prendre les dispositions administratives pour effectuer la paiement, passer les marchés et s'occuper de la distribution. Les détenteurs de contrats seront soumis à de strictes normes de qualité nouvellement imposées par la NLM.

COMITE CONSULTATIF DU CBSS

Le Comité consultatif du CBSS s'est réuni à l'ICIST le 3 décembre 1986. Ce comité conseille le directeur de l'ICIST qui y siège à titre de membre d'office du Comité et agit à titre de secrétaire.

Les membres sont nommées par l'Association des bibliothèques de la santé du Canada, le Comité spécial sur les ressources des bibliothèques médicales de l'Association des facultés de médecine du Canada et la Section de la santé de l'Association pour l'avancement des sciences et techniques de la documentation (ASTED).

Les membres actuels et la durée de leur mandat sont les suivants:

Anitra Laycock, ABSC	1983-1986	(présidente)
Louis-Luc Lecompte, ASTED	1983-1986	
Catherine Quinlan, ACMC	1986-1989	
Donna Dryden, ABSC	1986-1989	
Colin Hoare, ABSC	1986-1989	

La discussion a principalement porté sur les activités qui ont été entreprises à ce jour à la suite des recommandations du rapport conjoint présenté à l'ICIST par l'ACMC et la ABSC intitulé **The Role of the Health Sciences Resource Centre and Health Information Needs**. Il en sera question plus longuement dans les prochains numéros, mais on a effectivement assuré un suivi à plusieurs questions soulevées par le rapport. Il faut noter entre autres la réponse positive de la Bibliothèque canadienne du film scientifique à la demande d'acheter toutes les bandes vidéo produites par la NLM (voir l'article de Heather Moore de l'Institut canadien du film dans le présent numéro).

En outre, la chef du CBSS fait maintenant partie du Comité de rédaction des **Actualités ICIST** et depuis le numéro d'automne 1986, une rubrique est réservée au CBSS dans ce bulletin. De plus, toutes les bibliothèques qui figurent dans la 3e édition de la publication **Information en sciences de la santé au Canada: bibliothèques** seront placées sur la liste d'envoi des **Actualités ICIST**. En accord avec la recommendation du Comité consultatif, nous avons choisi les **Actualités ICIST** comme moyen de diffusion de l'information au sujet du CBSS plutôt que de faire paraitre un autre bulletin de nouvelles. Pour être placé sur la liste d'envoi, veuillez vous adresser à:

Section des publications de l'ICIST
Conseil national de recherches Canada
Ottawa (Ontario)
K1A 0S2

Numéro de téléphone: (613) 993-3736
ENVOY 100: CISTI.PUBS

NATIONAL SCIENCE FILM LIBRARY ADDS NEW TITLES

Heather Moore

Development and Communications Officer
Canadian Film Institute
Ottawa, Ontario

The Canadian Film Institute (CFI) is pleased to announce that its National Science Film Library (NSFL), located in Mississauga, Ontario, has recently added 45 new titles to its collection of over 3,600 science and medicine films and videos.

The National Science Film Library collection, sponsored by the Canada Institute for Scientific and Technical Information (CISTI), a division of the National Research Council Canada, has acquired 32 new 3/4 inch videotapes from the American National Library of Medicine (NLM). These videotapes deal with such subjects as pharmacokinetics, forensic pathology, patient education, cardiovascular studies, and descriptive epidemiology. Specific titles include **Cardiovascular Signs**, **Forensic Identification**, **Flame Photometry**, **General Concepts of Analytic Epidemiology**, and **Principles of Pharmacokinetics**.

With the assistance of CISTI, the CFI has also purchased the highly-acclaimed and eclectic 13 title Australian television series, **Breakthroughs**, which popularizes the latest developments in high technology and medical research. Titles include **Faces from the Grave**, a videotape about anthropological medicine and its use in historical autopsies; **The Big Shift**, which explores the area of advanced craniofacial surgery in deformed children; **The Silent Minority**, which details recent developments in surgery which bring fresh hope to victims of Down's syndrome; and **The New Solar Dawn**, a videotape about revolutionary solar energy systems.

In addition to these new acquisitions, the film library also circulates the film and videotape collections deposited by Health and Welfare Canada, the Royal College of Physicians and Surgeons, the Department of Energy, Mines and Resources Canada, the Department of Energy (United States), the National Aeronautics and Space Administration (United States), and Unesco. Many other science and medicine titles may be found in the deposit collections of various embassies and foreign missions.

Copies of the film library catalogue of the Canadian Film Institute may be obtained from its Mississauga office at a cost of $18.00 prepaid, or $25.00 with a purchase order. Contact the following for further information on these new acquisitions, the service charges of the CFI film library, or to request a film or videotape from the library:

Canadian Film Institute Film Library
211 Watline Avenue, Suite 204
Mississauga, Ontario L4Z 1P3

Telephone: (416) 890-1117

CINEMATHEQUE NATIONALE SCIENTIFIQUE AJOUTE DES NOUVEAUX TITRES

Heather Moore

Development and Communications Officer
Institut canadien du film
Ottawa (Ontario)

L'Institut canadien du film (ICF) a le plaisir d'annoncer que sa Cinémathèque nationale scientifique (CNS), située à Mississauga, Ontario, vient d'ajouter 45 nouveaux titres à sa collection de plus de 3600 films et bandes vidéo sur les sciences et la médecine.

La collection de la Cinémathèque nationale scientifique, comanditée par l'Institut canadien de l'information scientifique et technique (ICIST), une division du Conseil national de recherches Canada, a fait l'acquisition de 32 nouvelles bandes vidéo de 3/4" provenant de l'américain National Library of Medicine. Ces bandes vidéo présentent des sujets cliniques comme la pharmacocinétique, la pathologie légale, l'éducation des patients, les études cardiovasculaires et l'épidémiologie descriptive. Parmi ces titres (disponibles en anglais seulment), on remarque particulièrement **Cardiovascular Signs**, **Forensic Indentification**, **Flame Photometry**, **General Concepts of Analytic Epidemiology**, et **Principles of Pharmacokinetics**.

L'ICF a également acheté, avec l'aide de l'ICIST, les 13 émissions de la célèbre série **Breakthroughs** de la télévision australienne, qui offrent une vulgarisation des progrès les plus récents des technologies de pointe et de la recherche médicale. Les titres (disponibles en anglais seulment) comprennent **Faces from the Grave**, une bande vidéo traitant de la médecine anthropologique et de son utilisation pour les autopsies historiques; **The Big Shift**, qui explore le domaine de la chirurgie cranio-faciale de pointe chez les enfants mal formés; **The Silent Majority**, qui décrit les découvertes chirurgicales récentes offrant un nouvel espoir aux victimes du syndrome du Down; et **The New Solar Dawn**, qui présente des systèmes révolutionnaires d'utilisation de l'énergie solaire.

En plus de ces nouvelles acquisitions, la CNS assure la diffusion de collections de films et de bandes vidéo provenant de Santé et Bien-être social Canada, du Collège royal des médecins et chirurgiens du Canada, d'Energie, Mines et Ressources Canada, du Department of Energy (des Etats-Unis) et de l'Unesco. Plusieurs autres titres traitant de sciences et de médecine se retrouvent dans les collections déposées auprès de la CNS par diverses ambassades et missions étrangères.

On peut se procurer des exemplaires du catalogue de la cinémathèque de l'ICF en s'adressant au bureau de Mississauga de l'ICF. Le prix en est de 18$ si le paiement est effectué d'avance ou de 24$ avec un bulletin de commande. Pour obtenir des renseignments additionnels au sujet des nouvelles acquisitions, enquérir des tarifs pour les services de la Cinémathèque de l'ICF ou commander un film ou une bande vidéo, veuillez vous adresser à:

Cinémathèque de l'Institut canadien du film
211, avenue Watline, Bureau 204
Mississauga, Ontario L4Z 1P3

Téléphone: (416) 890-1117

HEALTH AND WELFARE CANADA'S NHRDP REPORTS AVAILABLE ON INTERLIBRARY LOAN

Betty H. Garland

Head, Library Services
Health Services and Promotion Branch Library
Ottawa, Ontario

The final reports on grants awarded under the National Health Research Development Program (NHRDP) have been relocated from the former Health and Welfare Departmental Library to the Health Services and Promotion Branch Library. Since takeover of this collection, over 50% of the final reports of the last four years have been catalogued and are now available for interlibrary loan.

Approximately half of the remaining 1,300 reports have also been recatalogued. Current final reports (about 25 per month) are being entered on DOBIS. By the end of May 1987, approximately 400 NHRDP documents will be on DOBIS and within the next two years, the entire NHRDP collection will be listed on that system.

For interlibrary loan of these documents, contact Nicole St. Denis, Health Services and Promotion Branch Library, 5th floor, Jeanne Mance Building, Ottawa, Ontario K1A 1B4. Telephone: (613) 954-8592.

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LES RAPPORTS FINALS DU PNRDS DE SANTE ET BIEN-ETRE SOCIAL CANADA SONT MAINTENANT DISPONIBLES POUR LE PRET-ENTRE-BIBLIOTHEQUE

Betty H. Garland

Chef, Services de bibliothèque
Bibliothèque de la Direction générale des services
et de la promotion de la santé
Ottawa (Ontario)

Les rapports du Programme national de recherche et de developpement en santé (PNRDS) qui étaient situés à l'ancienne bibliothèque de ministère de Santé et bien-être social Canada se trouvent à la bibliothèque de la Direction générale des services et de la promotion de la santé. Depuis la déménagement de cette collection, plus de 50% des rapports finals des quatre dernières années ont été catalogués et sont maintenant disponibles pour le prêt-entre-bibliothèque.

Environ la moitié des 1,300 rapports qui restent ont été recatalogués. Les rapports finals les plus récents (près de 25 par mois) sont entrées sur DOBIS. A la fin de mai 87, on retrouvera environ 400 documents de PNRDS sur DOBIS. D'ici deux ans la collection entière sera entrée sur le système DOBIS.

Pour un prêt-entre-bibliothèque, veuillez communiquer avec Nicole St. Denis, Bibliothèque de la Direction générale des services et de la promotion de la santé, 5e étage, Edifice Jeanne Mance, Ottawa (Ontario) K1A 1B4. Téléphone: (613) 954-8592.

PEOPLE ON THE MOVE

Beverly Brown, Technical Services Librarian for the past four years at the C.C. Clemmer Health Sciences Library of the Canadian Memorial Chiropractic College in Toronto will be moving to Winnipeg, Manitoba early in the new year in order to take up a position as Cataloguer in the University of Manitoba Medical Library on the 15th of January 1987.

Claire Callaghan, Director of the C.C. Clemmer Health Sciences Library of the Canadian Memorial Chiropractic College in Toronto left that position at the end of 1986 to become Collections/Online/Reference Librarian at the Sciences Library at the University of Western Ontario in London.

Tom Flemming, Head of Public Services at the McMaster University Health Sciences Library in Hamilton, Ontario was elected to the position of second vice-chair of the Upstate New York and Ontario Chapter (UNYOC) of the Medical Library Association at the association's annual meeting held in Buffalo, New York in October 1986. **Michael Ridley**, Head of Systems and Technical Services in the same library, was elected to the Board of UNYOC as a Member-at-large.

After 28 years as Cataloguer at the University of Manitoba Medical Library, **Love Negrych** has resigned in order to take up a position as Reference Librarian at the Architecture and Fine Arts Library of the University. Other resignations at the University of Manitoba Medical Library in the past year have seen **Sandra Fish** leave her position as Administrative Assistant after 14 years to go into the business world; **Florence Granke** left the Acquisitions Department of the Medical Library to take up early retirement and **Evelyn Gurvey** left the Circulation Department of the Medical Library, also for early retirement.

The inaugural meeting of the Manitoba Health Libraries Association was held on 20 October 1976 in Winnipeg, and the current President, **Doris Pritchard**, has begun a history of the association to commemorate its tenth anniversary. The first part of this history appeared in the October 1986 issue of the **MHLA News** (vol. 9(1):5-6).

The position of Director of the C.C. Clemmer Health Sciences Library of the Canadian Memorial Chiropractic College will be filled, as of 1 February 1987, by **Marilyn Schafer**, formerly Head of the Health Sciences Resource Centre at the Canada Institute for Scientific and Technical Information in Ottawa.

Lois Wyndham has been appointed librarian at the Chedoke Division Library of the Chedoke-McMaster Hospitals in Hamilton, Ontario. She has sixteen years of experience as a librarian; some of her time was spent as a librarian with Stelco, working with automated systems and online information retrieval, and some in teaching courses in the library techniques programs at Sheridan and Mohawk Colleges.

Ella-Fay Zalezak joined the staff of the C.C. Clemmer Health Sciences Library of the Canadian Memorial Chiropractic College in December 1986 as Cataloguing Librarian. She is a 1983 graduate of the Faculty of Library and Information Science at the University of Toronto and had worked as a cataloguer at the Toronto Public Library after her graduation.

Canadian Health Libraries Association / Association des Bibliothèques de la Santé du Canada 11th Annual Meeting
Theme: Maximizing resources: management, marketing, people, priorities.
Location: Holiday Inn Harbourside, Vancouver, British Columbia
24 - 27 May 1987

Contact: **Nancy Forbes**, Conference Co-ordinator, Biomedical Branch Library, 700 West Tenth Avenue, Vancouver, British Columbia V5Z 1L5 Telephone: (604) 875-4505

To tempt you further to attend next year's annual CHLA/ABSC meeting in Vancouver, the Planning Committee would like you to picture May on the West Coast. Rhododendrons, iris, and tulips are blooming in the parks and gardens, while flowering crabapple, dogwood and chestnut trees line the streets. Your hotel boasts wonderful harbourside views of the mountains (still a little snow on top ?), Stanley Park, Canada Place, and a bustling harbour. City-side views provide a panorama of Vancouver's best modern business and shopping areas. A revolving restaurant tops off the hotel, so diners can enjoy the spectacular scenery.

Close by your hotel, the Sea Bus can take you to shopping and sightseeing in North Vancouver, and the LRT (our new light rapid transit system) can take you to points southeast. The Vancouver Art Gallery is showing its permanent exhibit of works by Emily Carr, Robert Davidson, John Flaxman, and Joey Morgan, and a travelling exhibit from the Public Archives of Canada entitled *Our Painted Past*. The Vancouver Symphony Orchestra is performing its 5th Pops Concert in the magnificently refinished Orpheum Theatre, with Maestro Jack Everly conducting *Kismet*.

So come early and stay late. May in Vancouver is a wonderful time!

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MLA - CE 112 Workshop: Collection Development and Use.
Sponsor: Windsor Area Health Librarians Association (WAHLA)
Location: Chicken Court Restaurant, 531 Pelissier Avenue, Windsor, Ontario
5 May 1987

Contact: **Toni Janik**, Medical Library, Hotel Dieu Hospital, 1030 Ouellette Avenue, Windsor, Ontario N9A 1E1 Telephone: (519) 973-4444 x178; or **Anna Henshaw**, Staff Library, S.A. Grace Hospital, 339 Crawford Avenue, Windsor, Ontario N9A 5C6 Telephone: (519) 255-2245/255-2230.

This new MLA programme deals with collection development for both monographs and journals. Strategies for Quality Assurance and policy development will also be covered. Participants are urged to bring along copies of their library collection development policy. James Bobick, Associate Director of the Case Western Reserve University Libraries in Cleveland, Ohio, will be the instructor. The workshop fee of $60.00 (Canadian) or $45.00 (U.S.) will include lunch, coffee and course materials. Registration is limited to 30 participants; 27 February 1987 is the registration deadline. Make cheques payable to Mrs. Anna Henshaw, Secretary, WAHLA and send to the address shown above.

Medical Library Association 1987 Annual Meeting
Theme : Confluence: source of new energy
Location : Portland, Oregon, U.S.A.
15 - 21 May 1987

Contact : MLA Headquarters, Suite 3208, 919 North Michigan Avenue, Chicago, Illinois, U.S.A. 60611 Telephone: (312) 266-2456

Information about the 1987 MLA Annual Meeting is just now becoming available. The headquarters hotel in Portland will be the Portland Hilton, but several other hotels will also be used. Most conference activities will occur in the Memorial Coliseum.

The keynote speaker will be Fred Friendly, best known to the public as former President of CBS News and as host and producer of the American television series *Managing our miracles: healthcare in America*. Mr. Friendly's keynote address will be delivered on Sunday, 17 May 1987. Speakers in the Joseph Leiter Lecture series, to be delivered on Wednesday, 20 May 1987 at the conference, will be William F. Raub, Ph.D., of the National Institutes of Health and Warren J. Haas of the Council on Library Resources. The titles of these presentations were not available at press time.

The entire roster of MLA CE courses -- 19 in all -- is being presented on the 15th and 16th of May, before the conference itself begins. In addition, 10 *New Perspectives* courses are also being offered. Some of these more advanced courses have very interesting titles: *Using statistics in library management*, *Artificial intelligence and knowledge-based systems*, *Bibliographic control of software*. Further information on these courses, or on any other aspect of the conference is available from the MLA Headquarters at the address and telephone number shown above. Program information will soon be mailed to members.

Inclusive fee for the conference is $185.00 (U.S.) for members of the association, and $280.00 (U.S.) for non-members. Full pre-registration and program details are available from MLA Headquarters.

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A Bibliography of Health Care in Newfoundland (Occasional Papers in Medical History: number 6) by Isabel Hunter and Shelagh Wotherspoon. St. John's, Newfoundland: Faculty of Medicine, Memorial University of Newfoundland: 1986. 160 pages, 841 references, ISBN 0-88901-113-3. Price: $18.00 ($15.00 + $3.00 postage).

The work on this bibliography began in 1980; originally, it was expected to include about 200 references to published works on health care in Newfoundland. Six years, and some 800 references later, the librarian compilers are still not certain they have listed all of the published material on the subject and welcome news of additional citations which can appear in a later edition. Only published material was included and it all deals with institutions concerned with health, health education or illness in Newfoundland and Labrador, or discusses a disease or condition occurring in or peculiar to the province. Most of the material is held in the Health Sciences Library at Memorial University and can be seen there or obtained on Interlibrary Loan.

Order from: Medical History Room
Health Sciences Centre
Memorial University of Newfoundland
St. John's, Newfoundland A1B 3V6

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Taking Aim: Job Search Strategies for People with Disabilities. Toronto, Ontario: Ontario Ministry of Labour, Handicapped Employment Program: 1986. 106 pages. Free to residents of Ontario; $10.00 out of province. Requests from outside Ontario must be accompanied by a certified cheque or money order for $10.00.

This comprehensive manual for the disabled job-seeker has gathered a lot of information into a concise, easy-to-read and easy-to-use format. Yellow tabs, for example, assist the vision-impaired, while a spiral binding makes it easier to handle for those with dexterity problems. Examples of résumés and covering letters are found in the book, along with a step-by-step guide and lists of resources for the job-seeker. The book will be helpful to the disabled person who needs to assess his/her own skills and experience, who needs to identify areas where further training would be helpful or who needs practical advice on effective self-marketing. The manual is available in French, in English and on audio cassette.

Order from:

Handicapped Employment Program
Ontario Ministry of Labour
400 University Avenue, 10th floor
Toronto, Ontario M7A 1T7

Telephone; (416) 965-2321

Periodical Index for Quality Assurance in Canadian Health Care. Toronto, Ontario: Canadian Association of Quality Assurance Professionals: 1986. [Annual supplement to **Quality Assurance Quarterly**] 45 pages. 600 references. See below for price.

This new publication from the Canadian Association of Quality Assurance Professionals (CAQAP) lists over 600 references selected by the association's Education Committee from 1,500 citations submitted by the Quality Assurance (QA) Interest Group of the Toronto Health Libraries Association. The final selection was made on the basis of relevance to QA in Canada and ease of availability to Canadian health care professionals.

The citations are organized under 82 headings that conform to readily-identified hospital departments or services -- from *Admitting* to *Speech Therapy* -- and are therefore easily consulted. Future editions of the index will offer updated lists of papers on QA.

Cost of the publication (postage and handling included) is:

$7.50 for members of CAQAP
$8.50 for libraries
$10.00 for non-members

Order from:

Canadian Association of Quality Assurance Professionals
151 Bloor Street West, Suite 480
Toronto, Ontario M5S 1T3

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REVIEW OF SYDNEY DEVELOPMENT CORPORATION'S LIBRARY AUTOMATION SYSTEM

We draw our readers' attention to an interesting review of the Sydney Development Corporation's Library Automation System which appeared in the **MHLA/ABSM Bulletin**, number 9, for December 1986 (pp. 7-9). The brief review which appears there is the result of a demonstration of the system at the Maritime Health Libraries Association meeting in Moncton on 3 October 1986, but it offers a great deal of useful information. The author is Tim Ruggles of the Cataloguing Department at the W.K. Kellogg Health Sciences Library of Dalhousie University in Halifax, Nova Scotia.

Copies of the bulletin, or photocopies of the article, may be obtained from:

Christina Toplack, President
Maritime Health Libraries Association
Efamol Research Institute Library
P.O. Box 818
Kentville, Nova Scotia B4N 4H8

CORRECTION

[Editor's Note: The editor apologizes to Doctors L. Kabbash and N. Gilmore, authors of the paper *AIDS: an information perspective*, which appeared in **Bibliotheca Medica Canadiana** 1986; 8(2):71-8. Failure to proofread the final copy thoroughly permitted a wordprocessing "burp" to mar page 74 badly. The text, as it should have appeared on page 74 (complete under the heading: *Testing for HIV Infection*), appears below.]

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TESTING FOR HIV INFECTION

Antibody assays are the most sensitive and specific tests for HIV infection. However, anyone being tested should know that sufficient time must elapse before seroconversion occurs and that seronegativity is not conclusive evidence that infection has not occurred. They should also understand that neither extent of HIV injury nor prognosis can be defined by serological results. The social consequences of antibody testing for HIV infection have been extremely controversial. Among the more prominent bases for this are: potential damage to the person being tested if results become known (loss of privacy, employability, rights to shelter, educational opportunities, insurability etc.) and the psychosocial impact which test results can elicit. This includes the inability of testing to predict outcome. Early estimates of outcome suggest as many as 5% of HIV-infected persons may develop AIDS per year of seropositivity (4,20,25,31,32). What determines outcome following infection is unknown. No tests can predict whether or not an infected person will develop disease, or what diseases may result. Also, there is no way to stop the infection, once someone becomes infected, limit the damage this infection may produce, or repair the damaged immune system, once infection occurs. Meanwhile, therapy is directed at treating opportunistic infections or malignancies which result from this immunodeficiency.

Intensive research is being directed at developing a vaccine which would protect people from becoming infected, and antiviral drugs that would stop the infection once this has occurred. Until effective antiviral agents and/or a vaccine are developed, efforts to control HIV infection must be directed at preventing infection. All blood donations in every industrialized nation are now being screened to prevent HIV transmission by blood and blood products. Intensive efforts are underway to educate the public, especially persons at increased risk of becoming infected, or of infecting others. More and more pamphlets, brochures, guidelines, videos, government documents and reports are being produced to educate the public, especially high risk groups, about prevention.

AIDS is a costly illness (5,33). Increasing demands for already scarce resources are paralleling the increase in numbers of AIDS cases. Community-based support groups, hospices and hospital programmes are being developed to minimize the growing costs of AIDS and to ensure that care is available to anyone who is infected, or who has AIDS.

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